STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on clinical record review, interviews, and review of facility policy for 1 of 2 sampled residents (Resident #43) reviewed for care planning, the facility failed to allow a resident to participate in Resident Care Conferences (RCC). The findings include: Resident #43's diagnoses included dementia, hypertensive heart disease with heart failure, and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment, required maximal assistance for his/her personal hygiene and chair/bed to chair transfers, and used a manual wheelchair. The Resident Care Plan (RCP) dated 2/28/25 identified Resident #43 was dependent on staff for meeting his/her emotional, physical, and social needs related to physical limitations. Interventions included inviting the resident to scheduled activities, inviting the resident to attend special events, and providing the resident with materials for individual activities as desired. An interview with Resident #43 on 3/18/25 at 12:02 PM identified that he/she does not get invited to RCC's and would like to be invited and attend the meetings. A review of social service progress notes and RCC sign in sheets for the time period of October 2023 through March 2024 identified RCP meetings for Resident #43 were held on 10/24/23, 2/26/24, 5/29/24, 10/28/24, and 2/4/25. The RCC notes for the meetings failed to indicate if Resident #43 was invited, attended, or declined to attend. An interview with Social Worker #2 on 3/24/25 at 9:00 AM identified that residents were invited to RCC's even if they had a conservator. It was further identified if residents attended the RCC that would be documented on the sign-in sheet, while if a resident declined to attend the RCC then documentation would occur in social service progress notes. Social Worker #2 identified that Resident #43 was not being invited to RCP meetings and stated this was due to a request made by the resident's conservator for him/her not to attend as he/she takes over the meeting by voicing his/her concerns. Social Worker #2 failed to provide any documentation referencing the request made by the conservator not to invite Resident #43 to attend his/her own RCC. Attempts to contact Resident #43's conservator were unsuccessful. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the facility's Care Plans Policy identified that RCPs are to be completed and reviewed by the 21st day after admission and quarterly thereafter at the RCC. RCPs will include physical, cognitive, and psycho-social problems and will address the residents' needs on an individualized basis.

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 51182 Based on review of the facility's Personal Funds Account, review of facility documentation, facility policy and interviews, the facility failed to ensure necessary coverage through a surety bond for the Resident Trust Accounts. The findings include: On 3/20/25 at 3:23 PM, interview and review of the Resident Trust Account (RTA) balances with the Business Office staff indicated that the RTA balance for the period of 2/1/25 through 2/28/25 ranged from $76,586.13 dollars to $142,392.69. Additionally, the RTA balance for the period of 6/1/24 through 6/30/24 indicated a balance ranging from $63,261.77 to $109,338.53. The RTA balance for the period of 8/1/24 to 8/31/24 identified a balance ranging from $65,134.70 to $118,534.21 during that time. The RTA balance for the period of 9/1/24 through 9/30/24 identified a balance ranging from $66,003.21 to $116,259.39 during that time. The RTA balance for the period of 10/1/24 through 10/31/24 identified a balance ranging from $62,879. 01 to $105,474.01 during that time. The RTA balance for the period of 11/1/24 through 11/30/24 identified a balance ranging from $65,868.36 to $120,533.78 during that time. The RTA balance for the period of 12/1/24 through 12/31/24 identified a balance ranging from $72,205.01 to $141,842.27 during that time. Furthermore, the RTA balance for the period of 1/1/25 through 1/31/25 indicated a balance ranging from $72,682.68 to $149,270.15. Review of the facility's surety bond identified the Resident Trust Accounts were insured for $50,000 effective June 30, 2024, through June 30, 2025. An interview with the Administrator on 3/20/25 at 3:43 PM identified the facility did not regularly monitor if the Resident Trust Account $50,000 surety bond coverage was adequate and indicated he was unaware that the Resident Trust Account regularly exceeded the $50,000 coverage limit. The Administrator failed to identify who was responsible for monitoring the Resident Trust Account and indicated he was going to reach out to the Executive [NAME] President to raise the surety bond amount to cover resident funds. The facility failed to provide a Surety Bond Policy upon request.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observations, interviews, and review of facility policy for 6 of 6 sampled residents (Resident #2, Resident #7, Resident #43, Resident #70, Resident #79, and Resident #82) reviewed for dignity, the facility failed to provide clean bed and bath linens that were in good condition and in sufficient quantity for performing resident care tasks, and for the environment, the facility failed to ensure a safe and secured area on a locked, memory care unit. The findings include: 1a. Resident #2's diagnoses included chronic obstructive pulmonary disease, heart failure, and type 2 diabetes. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was cognitively intact, dependent with showering and bathing, required set-up assistance with personal hygiene, and was independent with ambulation. An interview on 3/24/25 at 9:34 AM with Resident #2 identified the facility ran out of washcloths quite often, but he/she was not sure how many times a week there were no washcloths available. A lack of towels has impacted his/her ability to get a shower on a few occasions resulting in his/her having to use baby wipes purchased independently. Resident #2 stated he/she was not happy with the insufficient number of towels and washcloths and felt too intimidated to complain to management. b. Resident #7's diagnoses included disease of the spinal cord, malignant neoplasm of the transverse colon, and chronic systolic heart failure. The quarterly MDS assessment dated [DATE] identified Resident #7 was cognitively intact, dependent with showering and bathing, required maximal assistance with personal hygiene, and utilized a motorized wheelchair for mobility. An interview on 3/17/25 at 12:36 PM with Resident #7 identified he/she only showered once a week and his/her shower day was often delayed due to the facility running out of towels. According to Resident #7, washcloths were made of cut up used towels, and sheets and that pillowcases were not changed often enough resulting in him/her having to sleep on dirty bed sheets. A follow-up interview on 3/20/25 at 11:57 AM with Resident #7 identified when the staff did not use washcloths to clean him/her, he/she felt unclean and demeaned by the facility because he/she was not important enough to have adequate supplies. c. Resident #43's diagnoses included dementia, hypertensive heart disease with heart failure, and osteoarthritis. The quarterly MDS assessment dated [DATE] identified Resident #43 was cognitively intact, required maximal assistance with showering/bathing, personal hygiene, and chair/bed to chair transfers. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 3/19/25 at 1:26 PM with Resident #43 identified NA's ran out of towels and instead use a bed sheet to dry him/her off. Resident #43 further identified that the facility also ran out of washcloths and when he/she needed incontinence care the NA's used Chux (blue, disposable, incontinence protectors) pads, or one half of a towel to wash and the other half to dry. Resident #43 stated he/she has complained to the Director of Nursing Services but was told there were not enough washcloths and towels in the facility. d. Resident #70's diagnoses included type 2 diabetes, chronic kidney disease, and an amputation. The quarterly MDS assessment dated [DATE] identified Resident #70 was cognitively intact, required moderate assistance with showering and bathing, and was independent with personal hygiene, and used a manual wheelchair for mobility. An interview on 3/24/25 at 9:34 AM with Resident #70 identified the facility ran out of washcloths 1 to 2 times per week. Although it did not directly impact him/her receiving care, Resident #70 stated it was unacceptable for the facility to not care enough to ensure the residents had washcloths to use. Resident #70 noted that not having washcloths and towels to wash up with felt undignified. e. Resident #79's diagnoses included chronic obstructive pulmonary disease, heart disease, and type 2 diabetes. The annual MDS assessment dated [DATE] identified Resident #79 had moderately impaired cognition, required moderate assistance with showering and bathing, required set-up assistance with personal hygiene, and was independent with ambulation. An interview on 3/24/25 at 9:34 AM with Resident #79 identified that he/she had not received a shower several times due to lack of washcloths and towels. It was further identified the facility ran out of washcloths a lot, although he/she cannot recall the dates this occurred. f. Resident #82's diagnoses included chronic kidney disease, hypertension, and dementia. The annual MDS assessment dated [DATE] identified Resident #82 had moderately impaired cognition, required moderate assistance with showering and bathing, required supervision with personal hygiene, and was independent with ambulation. An interview on 3/24/25 at 9:34 AM with Resident #82 identified he/she had experienced the facility's lack of washcloths, but this had not caused a delay in his/her care. Resident #82 further identified his/her Nurse Aide (NA) had always been able to search to find a towel while the resident waited, if one was needed. An interview on 3/17/25 at 2:16 PM with Housekeeper #2 identified laundry was not washed in the facility and was sent out for washing services. She further identified that towels, face cloths, hospital gowns, and pads were delivered by truck twice a day, once in the morning and once in the afternoon. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Environmental Services (EVS) on 3/17/25 at 2:18 PM identified that the afternoon delivery of laundry had been delivered for this day and the next delivery would occur between 7:30 AM and 8:00 AM on 3/18/25 from their sister facility who provided laundry services. An observation and count of linens located in the facility was performed with the Director of EVS, identifying 14 washcloths, 58 hospital gowns, and 17 hand towels. This amount of linen was noted to be for the entire facility census of 104 residents and needed to service both the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts to provide resident care. It was further identified that the same number of linens was delivered daily, the laundry turn-around time was 24 hours, and if she was notified by staff that washcloths or towels had run out there was nothing that she could do until the next scheduled delivery of laundry. The Director of EVS stated the Administrator was aware of the low stock and she completed a laundry count with him daily. An interview on 3/17/25 at 2:27 PM with NA #8 identified the facility ran out of washcloths and towels several times a month. She noted that when staff ran out of washcloths, they would cut up blankets to make their own. An interview with the Administrator on 3/17/25 at 2:38 PM identified he participated in a count of laundry items daily or every other day with the Director of EVS. He identified each resident was budgeted for 3 washcloths. An observation and count of washcloths with the Administrator identified 12 washcloths total on the main unit and an additional 2 washcloths on the locked memory care unit. The Administrator stated he was informed in the morning that laundry items were running low and noted he failed to take any action to get more laundry delivered. Furthermore, he identified he was aware that staff needed to cut up blankets to make washcloths when the facility supply of washcloths had run out. Subsequent to surveyor inquiry the Administrator contacted their sister facility for an additional laundry delivery. An interview with the Assistant Director of Nursing (ADNS) on 3/20/25 at 8:23 AM identified staff had complained to her about the insufficient numbers of laundry items being delivered to the facility. She further identified she was aware staff cut up bedcovers and blankets when laundry items ran out, and she had notified the Administrator and Director of EVS of the staff complaints in the past. The Linen Stocking Policy and Procedure identified the facility maintains a systematic process for receiving, storing, and distributing linens to each unit to ensure all units have an adequate supply of laundry. The policy failed to outline a process for what occurs when there is not an adequate supply of laundry. 2. An observation with the Director of Maintenance on 3/17/25 at 11:50 AM on the secured locked memory care unit identified the locking mechanism on the door jamb labeled Shower Room was broken preventing the keypad from locking. The unlocked door allowed resident access to the shower room. There were no accessible sharps in the room and a stationary container of wall soap containing pink liquid was noted. An interview with the Director of Maintenance on 3/17/25 at 11:50 AM identified he was unaware the door lock was malfunctioning and would address the matter immediately. A subsequent observation and interview with the Administrator on 3/17/25 at 12:05 PM identified he was unaware of the shower room locking mechanism malfunction on the secured unit and would have staff stationed at the entrance of the door until repaired for resident safety. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A third observation on 3/17/25 at 12:30 PM identified no staff at the entrance of the door or immediate area with a resident standing at the nurse's station approximately 10-15 feet from the entrance to the shower room. The Administrator was summoned to the unit where he remained stationed by the shower room door. An interview with the Administrator on 3/17/25 at 12:30 PM identified the staff assigned to monitor the area had to leave but was unable to explain why the responsibility was not reallocated to a different staff member. The Administrator indicated that he would remain at the entrance until supervision could be reassigned. The door was subsequently repaired on 3/17/25 in the afternoon. Although requested, a policy for ensuring a safe and secure environment on the memory care unit was not provided.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observation, interviews, clinical record reviews, facility documentation, and facility policy for 3 of 6 sampled residents, (Resident #43, Resident #42, and Resident #84) reviewed for abuse, for Resident #43, the facility failed to protect the residents' right to be free from physical abuse by staff, and for Resident #42 and Resident #84, the facility failed to protect the resident's right to be free from physical abuse by a resident. The findings include: 1. Resident #43's diagnoses included dementia, personality disorder, and hypertensive heart disease with heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, did not experience episodes of delusions, and required maximal assistance for his/her toileting hygiene and chair to bed and bed to chair transfers. The MDS further indicated that Resident #43 did not reject evaluations of care including Activity of Daily Living assistance and was always incontinent of urine. The Resident Care Plan (RCP) in effect on 1/3/25 identified Resident #43 experienced frequent episodes of incontinence of bladder with an intervention of an assist of 2 with toileting upon request. The RCP further identified he/she had a behavior problem of making accusatory statements towards staff. Interventions included explaining all procedures to him/her before starting and allowing him/her to adjust to the changes, monitoring behavior episodes to determine the underlying cause, and documenting the behavior and potential cause. The Resident Care Card in effect on 1/3/25 identified Resident #43 was to have 2 staff members present at all times when in his/her room including when performing bathing and toileting tasks. An observation and interview with Resident #43 on 3/18/25 at 11:43 AM identified that he/she was sitting in the hallway in a wheelchair, hands flailing, crying, verbalizing he/she was upset regarding a financial matter. The resident verbalized, in the presence of Licensed Practical Nurse (LPN) #8, he/she had been hurt by staff on multiple occasions, most recently by LPN #7. The Director of Nursing Services (DNS) was called by LPN #8 to come to the resident's room regarding the allegation of abuse. An interview with Resident #43 on 3/18/25 at 11:51 AM was conducted by the surveyor in the presence of the DNS. Resident #43 alleged a few weeks prior, while he/she was trying to get into bed from his/her wheelchair, LPN #7 reached over the back of the wheelchair and pushed him/her onto the bed in a non-sexual manner. Resident #43 further identified that he/she was alone in the room with LPN #7 and started yelling for help, at which point LPN #7 grabbed the phone out of his/her hand and threw it across the room. It was noted by Resident #43, that Nurse Aide (NA) #7 entered the room and assisted him/her into bed in order to provide incontinence care. Resident #43 stated he/she experienced great humiliation over the event and continued to be afraid of LPN #7, noting LPN #7 continued to come into his/her room to provide care after the alleged incident of abuse. The DNS identified he was aware of the allegation of abuse and stated he had completed an investigation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview and review of abuse documentation with the DNS on 3/19/25 at 7:51 AM identified a Reportable Event (RE) form dated 1/3/25 indicating Resident #43 alleged LPN #7, with help from NA #7, picked up the resident threw him/her into bed. Actions taken indicated LPN #7 and NA #7 were off of the schedule until the investigation was completed and would no longer provide routine care to Resident #43. Although requested, the DNS failed to provide documentation of a thorough investigation or any investigation whatsoever, except for a summary that he had created describing what had transpired on 1/3/25. The summary of events was typewritten, noted to be undated, unsigned, and lacked the alleged staff members name. The investigation/summary provided lacked any staff interviews, staff statements, an interview with Resident #43, any resident interviews who may have witnessed or overheard the incident, or an interview with the staff member (LPN #7) against whom the allegation was made. The DNS indicated he would have to look for the completed investigation he had done and for the creation date of the summary provided. Other than a history of allegations by Resident #43 against staff, (noted in the resident's care plan), the DNS was unable to explain how he had reached a conclusion that the allegation was unsubstantiated, and LPN #7 was allowed to return to providing care to Resident #43 upon the conclusion of the investigation. In an interview with the DNS and Administrator on 3/19/25 at 9:45 AM the DNS identified the nursing note written by LPN #7 on 1/5/25 (2 days after the allegation), which stated Resident #43 alleged to be thrown into bed, and not pushed, invalidated the allegation. The DNS deduced LPN #7 was not strong enough to throw the resident, adding this made all the difference in the outcome of his investigation During a review of the facility abuse policy with the DNS, he stated that he had not needed to remove LPN #7 from the schedule as the LPN was not scheduled to work on 1/4/25 when he concluded his investigation. On 3/19/25 at 10:30 AM the DNS stated that he was unable to locate any of the sworn statements from the investigation following the abuse allegation on 1/3/25. An interview and review of nursing progress notes with LPN #7 on 3/19/25 at 4:26 PM identified that Resident #43 refused to be assisted with incontinence care when he worked on the second shift (7:00 PM to 10:45 PM) and remained wet. LPN #7 stated he worked on third shift (10:45 PM to 7:30 AM) and indicated that Resident #43 again declined to be assisted with incontinence care and that was when LPN #7 informed the resident that he/she had to be changed. LPN #7 stated that he would not be held responsible for the development of a urinary tract infection or (pressure) sore for Resident #43, so he provided the incontinence care despite Resident #43's objections. When NA #7 assisted putting the resident back to bed with LPN #7 they began to provide the incontinence care, and that was when Resident #43 began crying and yelling for help. LPN #7 remarked this was when he removed the phone from the resident's hand and told Resident #43 he/she could call for help when he was done. LPN #7 indicated he removed the phone because he could not reposition the resident if he/she was holding onto the phone. On the advice of the DNS, to protect himself, LPN #7 indicated he wrote a late progress note on 1/5/25 at 6:30 AM (2 days after the incident and when he worked on 1/4/25 into 1/5/25). Further the progress note documented that the resident drew blood from LPN #7 in the process of LPN #7 transferring him/her back to the bed and that Resident #43 screamed, yelled, scratched, and hit staff during the incontinence care. LPN #7 indicated that Resident #43 was always crying about everything Boo Hoo Hoo this and Boo Hoo Hoo that and no one wanted to work with him/her because he/she cried about everything. LPN #7 stated that although he had subsequently spoken to the DNS about the incident, he was never asked by the DNS to write a statement. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In a follow up interview with the DNS and Administrator on 3/20/25 at 8:36 AM the DNS indicated he had not yet begun an investigation into the allegation from 1/3/25, per the facility policy, and following the 3/18/25 interview with Resident #43 and the surveyor. The DNS stated the reason he had not done so was that he wanted to confirm with the surveyor first, but did not specify what he wanted to confirm. An interview and review of NA #7's written and undated statement (created on 3/19/25 at the DNS request) with the DNS on 3/20/25 at 2:14 PM identified Resident #43 was fighting back and needed redirection multiple times during the 1/3/25 incident. The DNS reiterated that because Resident #43 was not thrown on the bed (was pushed), the abuse was unfounded. The DNS was informed by the surveyor that the abuse had been investigated and had been substantiated through the investigative process, by the surveyor. The DNS indicated that he would redo his investigation. According to punch in and punch out records, LPN #7 punched in on 3/24/25 at 11:00 PM and punched out on 3/25/25 at 7:30 AM. A review of the staffing schedules identified that LPN #7 had been assigned to Resident #43's unit. Despite informing the DNS on 3/20/25 at 2:14 PM that the allegation of abuse had been substantiated by the surveyor, and LPN #7 had admitted to providing care to the resident against his/her will, LPN #7 was allowed to return to the facility, scheduled to work on Resident #43's unit, and worked in the facility on 3/24/25 on the 11:00 PM to 7:30 AM shift. An interview on 3/25/25 at 11:03 AM with the DNS identified that residents have the right to refuse care. He further identified if a resident refused care, staff should document the refusal and reapproach later. The DNS identified that forcing a resident to receive care they had refused fell under the category of abuse. Although the DNS indicated to the surveyor that he would begin an investigation on 3/20/25, he stated that he still had not read LPN #7's progress note indicating Resident #43 had drawn blood (although the DNS summary written on 3/18/24 did identify LPN #7's blood was drawn) during the incident. The DNS stated he needed to investigate the 1/3/25 incident more thoroughly. Subsequent to surveyor inquiry, LPN #7 was removed from the staff schedule. A review of LPN #7's punch card identified LPN #7 had access to Resident #43 on 62 different shifts for the time period of 1/4/24 through 3/19/25, and again on 1/24/25. 2.a. Resident #42 had diagnoses that included dementia and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #42 had severe cognitive impairment with a Brief Interview of Mental Status BIMS of 0 and was independent with ambulation. The Resident Care Plan dated 10/23/24 identified Resident #42 had impaired thought processes, and an ADL deficit related to cognition. Interventions included to cue, orient and supervise as needed and provide supervision with ambulation. A nurse's note dated 11/23/24 at 7:07 PM identified Resident #42 was in the hallway when s/he attempted to prevent another resident (Resident #84) from pushing an item. During the interaction, Resident #84 became agitated and struck Resident #42 open handed on the right cheek. The residents were immediately separated and Resident #84 placed on 1:1 monitoring. The DNS, responsible party, physician and police were notified. Resident #42 had no complaints of pain, and no signs of bruising at the time of the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Resident Care Plan was revised to include redirection away from situations that may cause conflict. b. Resident #84 had diagnoses that included dementia and delusional disorders. The annual MDS assessment dated [DATE] identified Resident #84 had moderately impaired cognition and was independent with bed mobility, transfers, and ambulation. The Resident Care Plan dated 10/7/24 identified Resident #84 had a history of inappropriate/disruptive behavioral symptoms evidenced by unprovoked aggression towards others. Interventions included anticipating needs and intervene as necessary to protect the rights of others. An unsigned Resident Monitoring Sheet dated 11/23/24 identified 6:15 PM through 6:30 PM Resident #84 was in the hall. A nurses note dated 11/23/24 at 7:09 PM identified Resident #84 was walking down the hall pushing an item. (Resident #42) attempted to stop him/her (from further movement) resulting in Resident #84 striking Resident #42 on the right cheek open handed. Resident #84 was placed on 1:1 supervision and returned to his/her room. The responsible party, physician. DNS, and police were notified. A facility Reported Event Summary dated 11/26/24 identified on 11/23/24 at approximately 6:30 PM, Resident #84 was pushing a wheelchair in the hallway. Resident #42 stepped in front (of resident #84) to prevent further movement. This upset Resident #84 who slapped Resident #42 with an open hand on the right side of his/her face. LPN #14 was passing medication in the hallway and observed the altercation but was unable to respond quickly enough to intervene. The residents were separated and immediately placed on a 1:1 sitter until details could be obtained and assessments by the RN supervisor completed. An assessment identified both residents at baseline with no injuries to Resident #42. Once details were sorted out, Resident #84 remained on a 1:1 sitter until cleared by the health provider. Resident #84's prescribed Trazadone (an antidepressant) was increased from 25 mg daily to 50 mg. Resident #84 was subsequently transported to an alternate (psychiatric) facility for evaluation and treatment on 11/25/24. An interview with LPN #14 on 3/24/25 at 11:49 AM identified she was the assigned nurse on 11/23/24 during the 3:00 PM to 11:00 PM shift. LPN #14 indicated while passing medications, she observed Resident #84 pushing a cart down the hall. Resident #42 attempted to stop Resident #84 from pushing the cart at which point, Resident #84 slapped Resident #42 open handed on the side of the face. In response, Resident #42 pushed Resident #84 into the wall. LPN #14 immediately intervened, separated the two residents and notified the nursing supervisor. An interview with the DNS on 3/24/25 at 1:30 PM identified Resident #84 was pushing an item down the hallway when Resident #42 attempted to stop him/her. Resident #84 slapped Resident #42 in the face. No injuries were noted as a result of the incident. The DNS further identified he was not aware Resident #42 had also pushed Resident #84 as this detail was not previously reported or documented in any written statements, though it should have been reported at the time of the incident. Attempts to interview RN #3, the assigned nursing supervisor were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy for Abuse directs that the facility does not condone abuse by anyone including staff members and other residents. Further, abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm of pain or mental anguish that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 50249 51182

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical records, facility policy, and interviews for 11 of 40 sampled residents (Resident #12, Resident #23, Resident #33, Resident #39, Resident #45, Resident #50, Resident #57, Resident #59, Resident #84, Resident #92 and Resident #254) reviewed for a placement on a secured memory care unit, the facility failed to identify the clinical criteria for the unit, failed to document the resident or representative was included in the decision for placement on the unit, failed to ensure a physician order for placement on the unit, failed to assess for initial placement on the unit, failed to reassess for continued appropriate placement on the unit, and failed to document that information for independent egress had been provided. The findings include: 1. Resident #12's diagnosis included Parkinson's disease, dementia and emphysema. The annual Minimum Data Set assessment dated [DATE] identified Resident #12 was severely, cognitively impaired and required substantial/maximal assistance with dressing, and supervision/touching assistance with transfers, and walking. The Resident Care Plan in effect from 12/23/24 through 3/27/25 identified Resident #12 was at risk for wandering and elopement and had impaired cognition, Interventions included to ensure a name bracelet was in place, name was posted outside of the resident's door, utilize a check in check out log, and wander guard bracelet per the physician order. 2. Resident #23's diagnosis included Parkinson's disease, dementia and diabetes. The admission Minimum Data Set assessment dated [DATE] identified Resident #23 was severely cognitively impaired and required supervision/touching assistance with dressing and independently transferred and walked. The Resident Care Plan dated 12/31/24 through 3/27/25 identified Resident #23 with impaired Cognition secondary to dementia and behavior symptoms: socially inappropriate/disruptive behaviors. Interventions included administering medications per physician's order, monitor and record effectiveness and any adverse side effects, allow distance in seating other residents, obtain a psychiatric consult/psychosocial therapy, and assess for placement in a specially designated therapeutic unit. 3. Resident #33's diagnosis included dementia, congestive heart failure and Parkinson's disease. The annual Minimum Data Set, dated dated dated [DATE] identified Resident #33 was moderately cognitively impaired and required partial moderate assistance with dressing, was independent with transfers, was independent walking short distances and required supervision/touching assistance for walking up to 150 feet. The Resident Care Plan in effect from 1/4/25 through 3/27/25 identified Resident #33 had cognitive loss related to dementia and was admitted for long term care. Interventions included assistance with medication management, therapy, and recreational activities. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An elopement evaluation dated 2/14/25 at 2:00 PM identified an elopement attempt in the last 30 days and Resident #33 was at risk for elopement. 4. Resident #39's diagnosis included Parkinson's disease, dementia, and chronic lymphocytic leukemia. The annual Minimum Data Set assessment dated [DATE] identified Resident #39 was severely cognitively impaired and required substantial/maximal assistance with dressing, partial/moderate assistance with transfers, and supervision/touching assistance for walking. The Resident Care Plan in effect from 12/30/24 through 3/27/25 identified Resident #39 had impaired cognitive function and thought process related to dementia. Interventions included administering medications as ordered, ask yes/no questions to determine Resident #39's needs, cue, reorient, and supervise as needed. 5. Resident #45's diagnosis included dementia, diabetes, and seizures. The admission Minimum Data Set assessment dated [DATE] identified Resident #45 was severely cognitively impaired and required supervision/touching assistance for upper body dressing and partial/moderate assistance for lower body dressing and was independent with transfers and walking. The Resident Care Plan in effect from 12/25/24 through 3/27/25 identified impaired cognition related to inattention, and wandering. Interventions included to ensure Resident #45 had an identification band in place, maintain a calm environment, check wander guard placement and function per physician's order, and when Resident #45 began to wander, provide comfort measures for basic needs, pain, hunger, toileting, too hot or too cold. 6. Resident # 50's diagnosis included dementia, hypothyroidism, and adult failure to thrive. The annual Minimum Data Set, dated dated dated [DATE] identified Resident #50 had long and short term memory problems, had severely impaired decision making skills, and was totally dependent on staff for transfers and dressing, and did not walk. The Resident Care Plan in effect from 12/18/24 through 3/27/25 identified impaired cognitive function and/or impaired thought process related to Alzheimer's dementia. Interventions included administering medications as ordered, monitor and document side effects and effectiveness, ask yes/no questions in order to determine Resident #50's needs, present just one thought, idea, question or command at a time. 7. Resident # 57's diagnosis included dementia, diabetes and colon cancer. An elopement evaluation dated 2/7/25 identified Resident #57 was not an elopement risk. The Admission Minimum Data Set assessment dated [DATE] identified Resident #57 was severely cognitively impaired and required partial/moderate assistance with dressing, supervision/touching with transfers and walking. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan in effect from 2/13/25 to 3/27/25 identified impaired cognition or thought process related to dementia and Resident #57 was admitted for long term care. Interventions included administer medications as ordered, engage in simple, structured activities, and avoid overly demanding tasks. 8. Resident #59's diagnosis included dementia, congestive heart failure and hypokalemia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #59 was cognitively intact and required supervision/touching with dressing and was independent with transfers and ambulation. The Resident Care Plan in effect from 2/3/25 through 3/27/25 identified Resident #59 was an elopement risk/wanderer related to dementia. Interventions included distract from wandering by offering pleasant diversions, food, conversation, and participation in recreation activities. Resident #59's triggers for wandering and eloping were restlessness, give medication per physician's orders, observe and report changes in cognitive status. 9. Resident # 84's diagnosis included dementia, diabetes, and congestive heart failure The admission Minimum Data Set, dated dated dated [DATE] identified Resident #84 was severely cognitively impaired and was dependent on staff for dressing, partial/ moderate assistance with transfers, and required supervision/touching assistance to walk 10 feet, and was dependent on staff to ambulate up to 150 feet. The Resident Care Plan in effect from 1/20/25 through 3/27/25 identified cognitive loss related to dementia, socially inappropriate, disruptive behavioral symptoms as evidenced by unprovoked aggression toward others. Intervention included assess orientation every shift, encourage socialization and recreation, administer medications as ordered, anticipate and meet Resident #84's needs. Additionally, to assess Resident #84 for continued placement in a specially designated therapeutic unit, provide psychiatric/psychologist consult. 10. Resident #92's diagnosis included paranoid schizophrenia, adult failure to thrive and anxiety disorder. The quarterly Minimum Data Set, dated dated dated [DATE] identified Resident #92 was cognitively intact and required set-up/clean up assistance with dressing and independent with transfers and dressing. The Resident Care Plan from 1/3/25 through 3/27/25 identified Resident #92 was admitted for long term care, had impaired cognition and was at risk for elopement/wandering, with impaired safety awareness, and history of attempts to leave the facility unattended. Interventions included involving in day-to-day activities, Resident #92 triggers for wandering/eloping with difficulty adjusting to placement, thoughts of returning to apartment, distract from wandering by offering pleasant diversions, structured activities, monitor location every 15 minutes if refused to wear a wander guard as ordered. 11. Resident #254's diagnosis included dementia, pleural effusion and chronic kidney disease. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set assessment dated [DATE] identified Resident #254 was severely cognitively impaired and required substantial/maximal assistance with dressing, transfers, and walking 50 feet. The Resident Care Plan in effect from 12/9/24 through 3/27/24 identified cognitive loss related to dementia and was admitted for long term care. Interventions included assessing orientation every shift, encouraging socialization and recreation, providing a calendar and clock, referring to the time of day, date and recent events, and using Resident #254's name when speaking with him/her. Observations during all days of the survey 3/17/25, 3/18/25, 3/19/25, 3/20/25, 3/21/25, 3/24/25, 3/25/25, 3/26/25, and 3/27/25 identified Resident #12, #23, #33, #39, #45, #50, #57, #59, #84, #92, and #254 residing on the secured memory care unit. The entrance and exit to the secured memory care unit had a door with a keypad that required a number code to enter and exit. Intermittent observations on all days of the survey identified only staff inputting the code for visitors and residents to enter and exit the unit. Review of the clinical records for Resident #'s 12, #23, #33, #39, #45, #50, #57, #59, #84, #92 and #254; residents on the secured memory unit, failed to identify clinical criteria for placement, failed to identify initial assessment and/or periodic reassessment for placement, failed to identify involvement by the resident or resident representative, failed to identify a physician order, and failed to document that information for independent egress had been provided for any of the residents residing on the unit. Interview with The Director of Nursing (DNS) on 3/24/25 at 1:27 PM identified the criteria for placement on the secured memory care unit was a diagnosis of dementia or Alzheimer's and wandering behaviors. Interview with the DNS and RN #4 on 3/24/25 at 1:30 PM identified there was no written criteria for admission to the secured memory care unit. There was no initial assessment for placement on the secured memory unit. There was no re-assessment performed for continued placement to remain on the secured memory care unit. There was no documentation that the resident or resident representative consented to being admitted to a secure memory care unit. The facility failed to have a policy for admission to the secured memory care unit. Additionally, after reviewing the regulation for involuntary seclusion, the DNS and RN #4 identified that the noted residents were involuntary secluded. Although requested, a facility policy for the secured memory care unit was not provided.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observations, interviews, review of the clinical record, facility documentation, and facility policy for 3 of 6 residents, (Resident #42, Resident #43, and Resident #84) reviewed for abuse, for Resident #42 and #84, the facility failed to ensure that a resident-to-resident altercation, and for Resident #43 that a staff-to-resident altercation, involving physical mistreatment was properly reported according to policies, failed to implement policies to ensure a resident was protected from abuse, and failed to establish abuse procedures for coordination with the Quality Assurance and Performance Improvement (QAPI) program. The findings include: 1.a.Resident #42 had diagnoses that included dementia and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #42 had severe cognitive impairment with a Brief Interview of Mental Status, BIMS of 0 and was independent with ambulation. The Resident Care Plan (RCP) dated 10/23/24 identified Resident #42 had impaired thought process, and an ADL deficit related to cognition. Interventions included to cue, orient and supervise as needed and provide supervision with ambulation. b. Resident #84 had diagnoses that included dementia and delusional disorders. The annual MDS assessment dated [DATE] identified Resident #84 had moderately impaired cognition and was independent with bed mobility, transfers, and ambulation. The RCP dated 10/7/24 identified Resident #84 had a history of inappropriate/disruptive behavioral symptoms evidenced by unprovoked aggression towards others. Interventions included anticipating needs and intervening as necessary to protect the rights of others. An unsigned Resident Monitoring Sheet dated 11/23/24 identified from 6:15 PM through 6:30 PM Resident #84 was in the hall. A statement dated and signed 11/23/24 identified at 6:30 PM Resident #42 was slapped by Resident #84 while pushing a cart. A facility Reported Event Summary dated 11/26/24 identified on 11/23/24 at approximately 6:30 PM, Resident #84 was pushing a wheelchair in the hallway. Resident #42 stepped in front (of resident #84) to prevent further movement. This upset Resident #84 who slapped Resident #42 with an open hand on the right side of his/her face. LPN #14 was passing medication in the hallway and observed the altercation but was unable to respond quickly enough to intervene. The residents were separated and immediately placed on a 1:1 sitter until details could be obtained and assessments by the RN supervisor completed. An assessment identified both residents at baseline with no injuries to Resident #42. Once details were sorted out, Resident #84 remained on a 1:1 sitter until cleared by the health provider. Resident #84's prescribed Trazadone (an antidepressant) was increased from 25 mg daily to 50 mg. Resident #84 was subsequently transported to an alternate (psychiatric) facility for evaluation and treatment on 11/25/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with LPN #14 on 3/24/25 at 11:49 AM identified she was the assigned nurse on 11/23/24 during the 3:00 PM to 11:00 PM shift. LPN #14 indicated while passing medications, she observed Resident #84 pushing a cart down the hall. Resident #42 attempted to stop Resident #84 from pushing the cart at which point, Resident #84 slapped Resident #42 open handed on the side of the face. In response, Resident #42 pushed Resident #84 into the wall. LPN #14 immediately intervened, separated the two residents and notified the nursing supervisor. LPN #14 further identified that although she had completed and signed a written statement, the statement failed to include the detail of Resident #42 pushing Resident #84 against the wall per the facility reporting policy, further explaining the omission as an oversight. An interview with the DNS on 3/24/25 at 1:30 PM identified he was not aware Resident #42 had also pushed Resident #84 as this detail was not previously reported or documented in any written statements, though it should have been at the time of the incident per the reporting policy. Attempts to interview RN #3, the assigned nursing supervisor were unsuccessful. 2. Resident #43's diagnoses included dementia, personality disorder, and hypertensive heart disease with heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 was cognitively intact, did not experience episodes of delusions, and required maximal assistance for his/her toileting hygiene and chair to bed and bed to chair transfers. The Resident Care Plan (RCP) in effect on 1/3/25 identified Resident #43 experienced frequent episodes of incontinence of bladder with an intervention of an assist of 2 with toileting upon request. The RCP further identified he/she had a behavior problem of making accusatory statements towards staff. Interventions included explaining all procedures to him/her before starting and allowing him/her to adjust to the changes, monitoring behavior episodes to determine the underlying cause, and documenting the behavior and potential cause. The Resident Care Card in effect on 1/3/25 identified Resident #43 was to have 2 staff members present at all times when in his/her room including when performing medication passes, answering call lights, and performing bathing and toileting tasks. An observation and interview with Resident #43 on 3/18/25 at 11:43 AM identified that he/she was sitting in the hallway in a wheelchair, hands flailing, crying, verbalizing he/she was upset regarding a financial matter. The resident verbalized, in the presence of Licensed Practical Nurse (LPN) #8, he/she had been hurt by staff on multiple occasions, most recently by LPN #7. The Director of Nursing Services (DNS) was called by LPN #8 to come to the resident's room regarding the allegation of abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with Resident #43 on 3/18/25 at 11:51 AM was conducted by the surveyor in the presence of the DNS. Resident #43 alleged a few weeks prior, while he/she was trying to get into bed from his/her wheelchair, LPN #7 reached over the back of the wheelchair and pushed him/her onto the bed in a non-sexual manner. Resident #43 further identified that he/she was alone in the room with LPN #7 and started yelling for help, at which point LPN #7 grabbed the phone out of his/her hand and threw it across the room. It was noted by Resident #43, that Nurse Aide (NA) #7 entered the room and assisted him/her into bed in order to provide incontinence care. Resident #43 stated he/she experienced great humiliation over the event and continued to be afraid of LPN #7, noting LPN #7 continued to come into his/her room to provide care after the alleged incident of abuse. The DNS identified he was aware of the allegation of abuse and stated he had completed an investigation and reported the incident to the State Agency (SA). An interview and review of abuse documentation with the DNS on 3/19/25 at 7:51 AM identified a Reportable Event (RE) form dated 1/3/25. Review of the RE failed to identify that the allegation of mistreatment had been reported to the SA, per the facility policy. Although requested, the DNS failed to provide documentation of a thorough investigation or any investigation whatsoever, per the facility policy, except for a summary he created following what had transpired on 1/3/25. (The summary was later found to have been created by DNS memory on 3/18/25). The investigation provided lacked any staff interviews, staff statements, an interview with Resident #43, any residents interviews who may have witnessed or overheard the incident, or an interview with the staff member (LPN #7) against whom the allegation was made. Further, the RE indicated that the immediate action taken by the facility was that LPN #7 would no longer deliver care to Resident #43 unless it was in an emergency. The DNS stated that once the investigation had been completed, he had proven that the allegation of abuse was unfounded because Resident #43 had a history of allegations against staff, which were noted in the Resident Care Plan. The DNS was unable to produce an investigation or to further explain how he had reached his conclusion other than based on Resident #43's history of allegations. Additionally, the DNS identified that LPN #7 was allowed to return to providing care to Resident #43 upon the conclusion of the investigation. An interview and review of nursing progress notes with LPN #7 on 3/19/25 at 4:26 PM identified that Resident #43 refused to be assisted with incontinence care when he worked on the second shift (7:00 PM to 10:45 PM) and remained wet. LPN #7 stated he worked on third shift (10:45 PM to 7:30 AM) and indicated that Resident #43 again declined to be assisted with incontinence care and that was when LPN #7 informed the resident that he/she had to be changed. LPN stated that he would not be held responsible for the development of a urinary tract infection or (pressure) sore for Resident #43, so he provided the incontinence care despite Resident #43's objections. When NA #7 assisted putting the resident back to bed with LPN #7 they began to provide the incontinence care, and that is when Resident #43 began crying and yelling for help. LPN #7 remarked that it was when he removed the phone from the resident's hand and told Resident #43 he/she could call for help when he was done. LPN #7 indicated he removed the phone because he could not reposition the resident if he/she was holding onto the phone. On the advice of the DNS, to protect himself, LPN #7 indicated he wrote a late progress note on 1/5/25 at 6:30 AM (2 days after the incident). Further the progress note documented that the resident drew blood from LPN #7 in the process of LPN #7 transferring him/her back to the bed and that Resident #43 screamed, yelled, scratched, and hit staff during the incontinence care. LPN #7 indicated that Resident #43 was always crying about everything Boo Hoo Hoo this and Boo Hoo Hoo that and no one wanted to work with him/her because he/she cried about everything. LPN #7 stated that although he had subsequently spoken to the DNS about the incident, he was never asked by the DNS to write a statement. (continued on next page)

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New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	According to punch in and punch out records, LPN #7 had punched in on 3/24/25 at 11:00 PM and punched out on 3/25/25 at 7:30 AM. A review of the staffing schedules identified that LPN #7 had been assigned to Resident #43's unit. Despite informing the DNS on 3/20/25 at 2:14 PM that the allegation of abuse had been substantiated by the surveyor, and LPN #7 had admitted to providing care to the resident against his/her will, LPN #7 was allowed to return to the facility, scheduled to work on Resident #43's unit, worked in the facility on 3/24/25 on the 11:00 PM to 7:30 AM shift, and had access to Resident #43. The facility failed to implement its abuse policy. Subsequent to surveyor inquiry, LPN #7 was removed from the staff schedule. A review of LPN #7's punch card identified LPN #7 had access to Resident #43 on 62 different shifts for the time period of 1/4/24 through 3/19/25, and again on 3/24/25. A review of the facility policy for Abuse Reporting directs all personnel must promptly report any incident or suspected incident of resident abuse. Additionally, the abuse policy directs facility staff who have been accused of abuse to be removed from the schedule pending the outcome of the investigation. Review of the facility's Reportable Events Policy identified that a Class B event, (state classification) including a complaint of resident abuse, should be reported to the State Department of Public Health and an investigation will be conducted by the facility after the discovery of an allegation of abuse. Review of the facility's Abuse Reporting Policy identified when an allegation of abuse is reported, the facility administrator or his/her designee will notify Department of Public Health; A completed copy of the Reportable Event Form and written statements from witnesses must be provided to the Administrator within 24 hours of the occurrence of said incident. Review of the Abuse Allegation and Investigation Policy directed, in part, to not allow employees to provide care independently or remove the employee from that unit or from the facility. 3. An interview with the Administrator on 3/27/25 at 9:46 AM identified the facility did not include QAPI as a component of their staff or volunteer training. Further the DNS identified the facility did not have any QAPI plan for abuse nor was the topic of abuse reviewed during QAPI/Quality Assurance and Assessment (QAA) meetings, stating he was not aware that he should have included abuse during QAPI meetings. Subsequent to surveyor inquiry, the Administrator noted that a QAPI plan for abuse would be developed and reviewed at future QAPI meetings. Review of the facility's Quality Assurance Improvement Plan policy identified, in part, that the DNS or Administrator are responsible and accountable for developing, leading and closely monitoring the QAPI program. Components of the QAPI plan included clinical care, quality of life, and resident choice. The QAPI plan failed to include how staff communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observation, clinical record reviews, facility documentation, facility policy and interviews for 4 of 6 sampled residents (Resident #42, Resident #43, Resident #45, and Resident #84) reviewed for abuse for Resident #84 and #42, and Resident #84 and #45, the facility failed to ensure resident to resident physical mistreatment was reported to state protective services, for Resident #84 and Resident #43, the facility failed to report resident to resident physical mistreatment to state protective services and failed to report the allegation timely to the state agency, and for Resident #43 for a staff to resident allegation of physical mistreatment, failed to report the allegation to state protective services and failed to report the allegation to the state agency. The findings include: 1. Resident #84 had diagnoses that included dementia and delusional disorders. The quarterly MDS assessment dated [DATE] identified Resident #84 had long and short term memory problems with moderately impaired cognition, decisions poor, cues supervision required, and was independent with bed mobility, transfers and ambulation. The RCP dated 10/7/24 identified Resident #84 had a history of inappropriate/disruptive behavioral symptoms evidenced by unprovoked aggression towards others. Interventions included anticipating needs and to intervene as necessary to protect the rights of others. a. Resident #42 had diagnoses that included dementia and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #42 had severe cognitive impairment with a Brief Interview of Mental Status, BIMS of 0 and was independent with ambulation. The Resident Care Plan (RCP) dated 10/23/24 identified Resident #42 had impaired thought process and ADL deficit related to cognition. Interventions included to cue, orient and supervise as needed and provide supervision with ambulation. A facility Reported Event dated 11/23/24 identified Resident #42 was struck open handed on the right side of the face by Resident #84 which did not result in any injury. The police, physician, and the party responsible were notified. A review of the clinical record for Resident #42 and Resident #84 failed to identify that protective services were notified of the alleged resident-to-resident physical altercation. b. Resident #45 had diagnoses that included dementia, anxiety disorder, and stroke. The quarterly MDS assessment dated [DATE] identified Resident #45 had moderate cognitive impairment with a BIMS of 9 and required 1 person assist with bed mobility and transfers, and was supervision with ambulation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RCP dated 10/17/24 identified Resident #45 had a communication deficit related to a stroke and expressive aphasia (partial loss of ability to produce sentences), and used psychotropic medications for anxiety, agitation, and depression. Interventions included anticipate/meet needs, provide a safe environment, observe resident state/behavior and report any changes to the physician. A facility Reported Event dated 11/15/24 identified Resident #45 alleged Resident #84 struck him/her in the right side of the face in response to Resident #45 telling him/her to f*** her/himself. The incident was unwitnessed. Both residents were separated and placed on 1:1 supervised monitoring. The medical director, APRN, DNS, responsible party, administrator, and police were notified of the incident. A review of the clinical record for Resident #45 and Resident #84 failed to identify that protective services was notified of the alleged resident-to-resident physical altercation. c. Resident #43 had diagnoses that included dementia and adult personality disorder. The quarterly MDS assessment dated [DATE] identified Resident #43 was cognitively intact with a BIMS of 15 and required substantial assist with bed mobility, transfer, and used a wheelchair for locomotion. The RCP dated 7/4/24 identified Resident #43 had a diagnosis of a serious mental illness and exhibited accusatory behavior. Interventions included providing socialization, monitor behavior to determine underlying cause and reassure the resident she/he was safe. A facility Reported Event submitted on 8/8/24 identified on 7/26/24 at 6:30 PM, (13 days post incident), that Resident #43 reported Resident #84 entered his/her room and slapped him/her 3 times. The nursing supervisor was notified, and an investigation was initiated. Staff confirmed Resident #84 was observed in a common area at the time Resident #43 reported she/he was being slapped. A review of the clinical record and facility documentation for Resident #43 and Resident #84 failed to identify that protective services were notified of the alleged resident-to-resident physical altercation. Additionally, the facility failed to report the allegation to the overseeing state agency in a timely manner. An interview with SW #1 on 3/24/25 at 9:39 AM identified, subsequent to recent surveyor inquiry, she indicated it was her responsibility to report allegations of mistreatment to protective services; however, she stated that she had not done so in the past. An interview with the DNS on 3/24/25 at 1:30 PM identified the facility did not report to any other state agencies outsight of Department of Public Health (DPH) but came to understand, subsequent to surveyor inquiry, that it was a requirement. Additionally, the DNS further indicated that for Resident #43, the report was not submitted to DPH timely due to an oversight. 2. Resident #43's diagnoses included dementia, osteoarthritis, and hypertensive heart disease with heart failure. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 was cognitively intact, required maximal assistance for chair to bed and bed to chair transfers and for personal hygiene, and used a manual wheelchair for ambulation. The Resident Care Plan (RCP) in effect on 1/3/25 identified Resident #43 had a self-care deficit related to dementia and impaired mobility. Interventions included monitoring for a decline in mobility function and notifying the supervisor, physician, and physical therapy as needed. The Resident Care Card in effect on 1/3/25 identified Resident #43 was to have 2 staff members present at all times when in his/her room including when performing bathing and toileting tasks. An observation and interview with Resident #43 on 3/18/25 at 11:43 AM identified that he/she was sitting in the hallway in a wheelchair, hands flailing, crying, verbalizing he/she was upset regarding a financial matter. The resident verbalized, in the presence of Licensed Practical Nurse (LPN) #8, he/she had been hurt by staff on multiple occasions, most recently by LPN #7. The Director of Nursing Services (DNS) was called by LPN #8 to come to the resident's room regarding the allegation of abuse. An interview with Resident #43 on 3/18/25 at 11:51 AM was conducted in the presence of the DNS. Resident #43 alleged a few weeks prior that while he/she was trying to get into bed from his/her wheelchair, LPN #7 reached over the back of the wheelchair and pushed him/her onto the bed in a non-sexual manner. Resident #43 further identified that he/she was alone in the room with LPN #7 and started yelling for help, at which point LPN #7 grabbed the phone out of his/her hand and threw it across the room. It was noted by Resident #43, that Nurse Aide (NA) #7 entered the room and assisted him/her into bed for the provision of incontinence care. Resident #43 stated she experienced great humiliation over the event and continued to be afraid of LPN #7, noting LPN #7 continued to come into his/her room to provide care after the alleged incident of abuse. The DNS identified he was aware of the allegation of abuse and stated he had completed an investigation and reported the incident to the State Agency (SA). An interview and review of facility documentation with the DNS on 3/19/25 at 7:51 AM requesting copy of a Reportable Event (RE) form referring to the incident of 1/3/25 and dated 1/4/25, identified the form had not been submitted to the SA. Interview with the DNS and Administrator on 3/19/25 at 9:45 AM identified the DNS had not submitted the RE form to the SA because Resident #43 was care-planned for prior allegations and did not like multiple staff members. Although the DNS identified that the allegation of mistreatment was an allegation of abuse, and that all allegations of abuse should be treated the same way, he indicated he made a mistake when he failed to submit the 1/3/25 allegation to the SA. The facility failed to report the incident of abuse to the SA or protective services after the interview with Resident #43 on 3/18/25 at 11:51 AM and after the interview with the surveyor on 3/19/25 at 7:51 AM during which the DNS was made aware that the surveyor substantiated Resident #43's allegation of abuse. In a follow up interview with the DNS and Administrator on 3/20/25 at 8:36 AM the DNS indicated he had not yet reported the allegation of mistreatment to the SA or protective services as he wanted to confirm first with the surveyor. The DNS was unable to specify what he wanted to confirm. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent to surveyor inquiry on 3/20/25 at 8:43 AM, the facility faxed a report of the 1/3/25 incident to protective services. Subsequent to surveyor inquiry, on 3/20/25 at 10:00 AM, the facility generated a report of the 1/3/25 incident which was submitted to the SA. A review of the facility policy for Abuse Reporting directs that any alleged violations involving mistreatment, neglect, or abuse, must be reported to the administrator or designee, i.e. immediate supervisor. When there is an allegation of suspected mistreatment, neglect, injuries of unknown source, or abuse is suspected, the facility administrator, or designee will notify the following agencies to include State Licensing and Certification Agency (Department of Public Health) no later than two hours after the allegation is made. Review of the facility's Reportable Events Policy identified that a Class B event, (state classification) including a complaint of resident abuse, should be reported to the State Department of Public Health by the Administrator or DNS within the required time frame. An investigation will be conducted by the facility after the discovery of an allegation of abuse. Although requested, a policy for reporting to state protective services was not provided. Connecticut state laws for Mandatory Reporting of Elder Abuse require certain professionals (i.e. mandated reporters) to report suspected abuse, neglect, abandonment, or exploitation of the elderly to the Department of Social Services (DSS) within 72 hours. They must also report to the department if they suspect an elderly person needs protective services [Connecticut Department of Social Service. (2018). Mandatory Reporting of Elder abuse Policy No. 2018-R-0068]. 50249 51182

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observations, interviews, review of the clinical record, facility documentation, and facility policy for 1 of 6 residents, (Resident #43) reviewed for abuse, the facility failed to thoroughly investigate an allegation of abuse, failed to remove the staff member from the schedule following the allegation, and once the allegation was substantiated by the State Agency again failed to remove the staff member from the schedule to ensure the residents were protected from abuse. These failures resulted in the finding of Immediate Jeopardy. The findings include: Resident #43's diagnoses included dementia, personality disorder, and hypertensive heart disease with heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, did not experience episodes of delusions, and required maximal assistance for his/her toileting hygiene and chair to bed and bed to chair transfers. The MDS further indicated that Resident #43 did not reject evaluations of care including ADL assistance and was always incontinent of urine. The Resident Care Plan (RCP) in effect on 1/3/25 identified Resident #43 experienced frequent episodes of incontinence of bladder with an intervention of an assist of 2 with toileting upon request. The RCP further identified he/she had a behavior problem of making accusatory statements towards staff. Interventions included explaining all procedures to him/her before starting and allowing him/her to adjust to the changes, monitoring behavior episodes to determine the underlying cause, and documenting the behavior and potential cause. The Resident Care Card in effect on 1/3/25 identified Resident #43 was to have 2 staff members present at all times when in his/her room including when performing medication passes, answering call lights, and performing bathing and toileting tasks. An observation and interview with Resident #43 on 3/18/25 at 11:43 AM identified that he/she was sitting in the hallway in a wheelchair, hands flailing, crying, verbalizing he/she was upset regarding a financial matter. The resident verbalized, in the presence of Licensed Practical Nurse (LPN) #8, he/she had been hurt by staff on multiple occasions, most recently by LPN #7. The Director of Nursing Services (DNS) was called by LPN #8 to come to the resident's room regarding the allegation of abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Resident #43 on 3/18/25 at 11:51 AM was conducted in the presence of the DNS by the surveyor. Resident #43 alleged a few weeks prior, while he/she was trying to get into bed from his/her wheelchair, LPN #7 reached over the back of the wheelchair and pushed him/her onto the bed in a non-sexual manner. Resident #43 further identified that he/she was alone in the room with LPN #7 and started yelling for help, at which point LPN #7 grabbed the phone out of his/her hand and threw it across the room. It was noted by Resident #43, that Nurse Aide (NA) #7 entered the room and assisted him/her into bed in order to provide incontinence care. Resident #43 stated he/she experienced great humiliation over the event and continued to be afraid of LPN #7, noting LPN #7 continued to come into his/her room to provide care after the alleged incident of abuse. The DNS identified he was aware of the allegation of abuse and stated he had completed an investigation and reported the incident to the State Agency (SA). An interview and review of the abuse documentation with the DNS on 3/19/25 at 7:51 AM identified a Reportable Event (RE) form dated 1/3/25 indicating Resident #43 alleged LPN #7, with help from NA #7, picked up the resident threw him/her into bed. Actions taken indicated LPN #7 and NA #7 were off of the schedule until the investigation was completed and would no longer provide routine care. Review of the RE failed to identify that the allegation of mistreatment had been reported to the SA. Although requested, the DNS failed to provide documentation of a thorough investigation or any investigation whatsoever, except for a summary that he had created indicating what had transpired on 1/3/25. The summary of events was typewritten, noted to be undated, unsigned, and lacked the alleged staff member's name. The investigation provided lacked any staff interviews, staff statements, an interview with Resident #43, any resident interviews who may have witnessed or overheard the incident, or an interview with the staff member (LPN #7) against whom the allegation was made. The DNS indicated that the summary provided was created by him following his conclusion to the investigation into Resident #43's allegation of abuse dated 1/3/25. The DNS stated that he would have to look for the sworn and signed statements by the staff as he was unable to locate the information, and he would have to reach out to Information Technology (IT) to obtain the creation date of the investigation summary that was provided to the surveyor. Further, the RE indicated that the immediate action taken by the facility was that LPN #7 would no longer deliver care to Resident #43 unless it was in an emergency. The DNS stated that once the investigation had been completed, he had proven that the allegation of abuse was unfounded because Resident #43 had a history of allegations against staff, which were noted in the Resident Care Plan. The DNS was unable to further explain how he had reached his conclusion other than based on Resident #43's history of allegations. Additionally, the DNS identified that LPN #7 was allowed to return to providing care to Resident #43 upon the conclusion of the investigation. Interview with the DNS and Administrator on 3/19/25 at 9:45 AM identified the summary provided by the DNS to the surveyor had not been created following the conclusion of the investigation of mistreatment as previously stated. The DNS indicated that when he realized he had not submitted the RE to the SA, he had become nervous and wrote up the summary on 3/18/25 based on his memory of the events on 1/3/25. Further, the DNS indicated the nursing note written by LPN #7 on 1/5/25, which stated Resident #43 alleged to be thrown into bed, and not pushed, invalidated the allegation as the DNS deduced LPN #7 was not strong enough to throw the resident, adding this made all the difference in the outcome of his investigation. On 3/19/25 at 10:30 AM the DNS stated that he was unable to locate any of the sworn statements from the investigation he indicated was conducted following the abuse allegation on 1/3/25. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with NA #7 on 3/19/25 at 10:54 AM identified that she had no recollection of any incident that occurred on 1/3/25 and that the DNS had never asked her about the incident or to write a statement for the investigation. Following the interview with NA #7 the DNS informed the surveyor he would have NA #7 write a statement to replace the one he indicated was written at the time of the incident on 1/3/25 but he was unable to locate. An interview and review of nursing progress notes with LPN #7 on 3/19/25 at 4:26 PM identified that Resident #43 refused to be assisted with incontinence care when he worked on the second shift (7:00 PM to 10:45 PM) and remained wet. LPN #7 stated he worked on third shift (10:45 PM to 7:30 AM) and indicated that Resident #43 again declined to be assisted with incontinence care and that was when LPN #7 informed the resident that he/she had to be changed. LPN #7 stated that he would not be held responsible for the development of a urinary tract infection or [pressure] sore for Resident #43, so he provided the incontinence care despite Resident #43's objections. When NA #7 assisted putting the resident back to bed with LPN #7 they began to provide the incontinence care, and that is when Resident #43 began crying and yelling for help. LPN #7 remarked that was when he removed the phone from the resident's hand and told Resident #43 he/she could call for help when he was done. LPN #7 indicated he removed the phone because he could not reposition the resident if he/she was holding onto the phone. On the advice of the DNS, to protect himself, LPN #7 indicated he wrote a late progress note on 1/5/25 at 6:30 AM (2 days after the incident). Further, the progress note documented that the resident drew blood from LPN #7 in the process of LPN #7 transferring him/her back to the bed and that Resident #43 screamed, yelled, scratched, and hit staff during the incontinence care. LPN #7 indicated that Resident #43 was always crying about everything Boo Hoo Hoo this and Boo Hoo Hoo that and no one wanted to work with him/her because he/she cried about everything. LPN #7 stated that although he had subsequently spoken to the DNS about the incident, he was never asked by the DNS to write a statement. In a follow up interview with the DNS and Administrator on 3/20/25 at 8:36 AM the DNS indicated he had not yet begun an investigation into the allegation from 1/3/25, per the facility policy, and following the 3/18/25 interview with Resident #43 and the surveyor. The DNS stated the reason he had not done so was that he wanted to confirm with the surveyor first, but did not specify what he wanted to confirm. An interview and review of NA #7's newly written and undated statement with the DNS on 3/20/25 at 2:14 PM identified Resident #43 was fighting back and needed redirection multiple times during the 1/3/25 incident. The DNS reiterated that because Resident #43 was not thrown on the bed [was pushed], the abuse was unfounded. The DNS was informed by the surveyor that the abuse had been investigated and had been substantiated through the investigative process, by the surveyor. The DNS indicated that he would redo his investigation. According to punch in and punch out records, LPN #7 had punched in on 3/24/25 at 11:00 PM and punched out on 3/25/25 at 7:30 AM. A review of the staffing schedules identified that LPN #7 had been assigned to Resident #43's unit. Despite informing the DNS on 3/20/25 at 2:14 PM that the allegation of abuse had been substantiated by the surveyor, and LPN #7 had admitted to providing care to the resident against his/her will, LPN #7 was allowed to return to the facility, scheduled to work on Resident #43's unit, and worked in the facility on 3/24/25 on the 11:00 PM to 7:30 AM shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 3/25/25 at 11:03 AM with the DNS identified that residents have the right to refuse care. He further identified if a resident refuses care, staff should document the refusal and reapproach later. The DNS identified that forcing a resident to receive care they had refused fell under the category of abuse. Although the DNS indicated to the surveyor that he would begin an investigation on 3/20/25, he stated that he still had not read LPN #7's progress indicating Resident #43 had drawn blood, although the DNS summary written 3/18/24 did identify blood was drawn during the resistance of care and he indicated he needed to investigate the 1/3/25 incident more thoroughly. Subsequent to surveyor inquiry, LPN #7 was removed from the staff schedule. A review of LPN #7's punch card identified LPN #7 had access to Resident #43 on 62 different shifts for the time period of 1/4/24 through 3/19/25, and again on 1/24/25. Review of the facility's Reportable Events Policy identified that a Class B event, (state classification) including a complaint of resident abuse, should be reported to the State Department of Public Health by the Administrator or DNS within the required time frame. An investigation will be conducted by the facility after the discovery of an allegation of abuse. The police are to be notified if an assault or suspected assault has occurred. Review of the facility's Abuse Reporting Policy identified when an allegation of abuse is reported, the facility administrator or his/her designee will notify the following persons of the incident: Department of Public Health; Ombudsman; Resident Representative; Law Enforcement Officials; and Primary Physician. Allegations of abuse must be reported no less than 2 hours after the allegation is made. A completed copy of the Reportable Event Form and written statements from witnesses must be provided to the Administrator within 24 hours of the occurrence of said incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 sampled residents (Resident #59) reviewed for unnecessary medications, the facility failed to review and revise the Resident Care Plan (RCP). The findings include: Resident #59's diagnoses included dementia, congestive heart failure, and bilateral sensorineural hearing loss. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 had severe cognitive impairment, required set-up assistance with eating, required supervision with personal hygiene, and was independent with ambulation. The Resident Care Plan (RCP) in effect on 3/24/25 identified Resident #59 had a communication problem related to being severely hard of hearing. Interventions included discussing with the resident and his/her family concerns or feelings regarding communication difficulties and encouraging the resident to continue stating his/her thoughts. A review of social service progress notes and Resident Care Conference (RCC) sign in sheets identified Resident #59 had a RCC on 10/8/24 but had not had any subsequent RCCs. An interview on 3/24/25 at 9:00 AM with Social Worker (SW) #2 identified RCCs were held on a quarterly basis to allow for RCP updating. SW #2 identified that the facility failed to hold a quarterly RCC for Resident #59 in January 2025 due to oversight. She further indicated Resident #59 was not on her list of RCCs to be scheduled in January 2025 and the MDS Coordinator made an error in not placing him/her on January's list. SW #2 noted Resident #59 was on her list of residents to schedule in March 2025 and she would try to hold his RCC during the week of 3/25/25-3/27/25. An interview with the MDS Coordinator, Licensed Practical Nurse (LPN) #15 on 3/24/25 at 9:18 AM identified she was responsible for creating a list of residents who needed a RCC, which is based off of their MDS completion date. She further identified she gives her list to the Administrative Assistant to call resident families and to collaborate with SW #2 in setting a date for the RCC. LPN #15 failed to locate a copy of the list of residents she provided to the Administrative Assistant for RCC scheduling in January 2025. Review of the Care Plan Policy identified, in part, the facility will complete an initial care plan within 21 days of a resident's admission and quarterly thereafter. The quarterly care plan will be developed no later than 7 days after the comprehensive MDS is completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical records, facility documentation, facility policy, and interviews for 22 of 40 residents (Resident #3, Resident #9, Resident #12, Resident #18, Resident #27, Resident #31, Resident #33, Resident #42, Resident #45, Resident #49, Resident #56, Resident #59, Resident #61, Resident #63, Resident #67, Resident #68, Resident #69, Resident #72, Resident # 74, Resident #78, Resident #81, Resident #92) reviewed during a tour of the secured memory unit, the facility failed to ensure the 5 Rights of medication administration, and professional standards of practice, were adhered to during the administration of medications. These failures resulted in the finding of Immediate Jeopardy. The findings include: 1. Resident #3's diagnoses included severe protein calorie malnutrition, cerebral infarction, and anxiety disorder. A physician's order dated 12/18/24 directed to administer Clopidogrel Bisulfate (antiplatelet) 75 milligrams (mg) orally once a day, Escitalopram Oxalate (antidepressant) 20 mg orally one a day, Multivitamin (supplement) 1 tablet orally once a day, Vitamin B Complex (supplement) 1 capsule orally once a day, Vitamin C (supplement) 1 tablet orally once a day, Vitamin D (supplement) 1 tablet orally once a day. A physician's order dated 1/19/25 directed to administer Aspirin 81 milligrams (mg) chewable orally once a day. A physician's order dated 2/2/25 directed to administer Trazadone 50 mg (antidepressant) orally twice a day, a physician's order dated 3/16/25 directed to administer Bupropion HCL ER (antidepressant extended release) 150 mg orally twice a day. 2. Resident #9 diagnosis included Alzheimer's dementia, diabetes, and congestive heart failure. A physician's order dated 8/6/24 directed to administer Memantine HCL (Anti-Alzheimer's) 5 mg orally1 tablet twice a day. A physician's order dated 8/7/24 directed to administer Aspirin 81 mg chewable orally once a day, Furosemide 20 mg (diuretic) 1 tablet orally once a day hold if systolic blood pressure is less than 100, Metformin HCL (antidiabetic) 500 mg 1 tablet orally once a day, Multivitamin 1 tablet orally once a day, Polysaccharide iron complex (supplement) 150 mg 1 capsule orally once a day, Toprol XL (extended release for high blood pressure) 25 mg 1 tablet orally once a day. A physician's order dated 8/9/24 directed Midodrine HCL (elevates blood pressure) 5 mg 1 tablet orally twice a day. A physician's order dated 2/21/25 directed to administer Tylenol extra strength 500 mg 2 tablets orally twice a day, 3. Resident #12's diagnosis included Parkinson's disease, dementia and emphysema. A physician's order dated 6/3/24 directed to administer Amlodipine (lowers blood pressure) 2.5 mg 1 tablet orally once a day, Carb/Levo (Parkinson's) 25-100 mg 1 tablet orally three times a day, Polyethylene Glycol powder (constipation) 3350 1 tablet once a day, Rivastigmine dis (Alzheimer's/Parkinson's) 9.5/24 apply 1 patch once a day trans dermally, Alendronate (osteoporosis) 70 mg 1 tablet orally once a day, aspirin chewable 81 mg 1 tablet orally once a day, Calcium /D 600-400 mg (supplement) 1 tablet orally once a day, Memantine 5 mg 1 tablet orally once a day, Vitamin D 1000 international units (IU) 2 caps orally once a day, Acetaminophen (pain) 500 mg 2 tablets orally twice a day, Budes/[NAME] Aer(emphysema) 160-4.5 120 Inh 2 puffs orally twice a day, Celecoxib cp (anti-inflammatory) 100 mg 1 capsule twice a day, Entacapone (Parkinson's) 200 mg 1 tablet orally twice a day. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	4. Resident #18 diagnosis included Alzheimer's dementia, diabetes, and depression. A physician's order dated 6/3/24 directed to administer Amlodipine 10 mg 1 tablet once a day, Aspirin low 81 mg 1 tablet orally once a day, Escitalopram 10 mg 1 tablet orally once a day, Hydrochlorothiazide (lowers blood pressure) tablet 25mg 1 tablet orally once a day, Losartan (lowers blood pressure) 50 mg 1 tablet orally once a day, Acetaminophen 500 mg tab orally twice a day, Metformin 1000 mg 1 tablet twice a day, Metoprolol Tar (lowers blood pressure) 50 mg 1 tab twice a day, A physician's order dated 10/29/24 directed to administer Potassium Chloride (elevates potassium) Liquid 20 milliequivalent/15 milliliter (mEq/ml) 20 met orally twice a day. A physician's order dated 1/14/25 directed Lantus Solostar (antidiabetic) subcutaneous solutions pen injector 100 unit/ml inject 16 units subcutaneously once a day. A physician's order dated 3/6/25 directed to administer Atorvastatin Calcium (lowers cholesterol) 20 mg 1 tablet orally once a day. A physician's order dated 3/7/25 directed to administer Fenofibrate (lowers cholesterol) 145 mg 1 tablet once a day. 5. Resident # 27 diagnosis included Dementia, Diabetes, and Epilepsy. A physician's order dated 5/30/24 directed to check blood sugars before meals and at bedtime. A physician's order dated 6/3/24 directed to administer Levetiracetam tabs (antiseizure) 500 mg give 1 tablet orally twice a day, Lisinopril (lowers blood pressure) 5 mg give 1 tablet orally once a day, Metformin tab 1000mg give 1 tablet orally twice a day, Metoprolol Tar 25mg tablet give 0.5 tablet orally twice a day, Risperidone (antipsychotic) 2 mg tabs Give 1 tablet orally twice a day, Insulin lisp injection 100/ml inject per sliding scale if blood sugar is 150 - 199 give 2 units, 200-249 give 3 units, 250-299 give 4 units, 300-349 give 5 units, 350-399 give 6 units, grated than 399 give 8 units and call the physician subcutaneously before meals and at bedtime. A physician's order dated 7/15/24 directed to administer Gabapentin (antiseizure) capsule 300 mg give 1 capsule orally three times a day. A physician's order dated 7/23/24 directed to administer Depakote(antiseizure) oral tablet delayed release 250 mg give 2 tablets orally once a day. A physician's order dated 9/17/24 directed to administer oyster shell (supplement) oral tablet 500 mg give 1 tablet orally once a day. A physician's order dated 9/28/24 directed to administer Celexa (antidepressant) oral tablet 20 mg give 30 mg orally once a day. A physician's order dated 10/16/24 directed Celebrex (non-steroidal anti-inflammatory) oral capsule 100 mg give 1 capsule orally twice a day. A physician's order dated 10/24/24 directed to administer Oxycodone HCL (opioid pain reliever) tablet 5 mg, give 5 mg orally three times a day. A physician's order dated 11/5/24 directed to administer Amantadine (Parkinson's like symptoms) 100 mg caps give 2 capsules orally twice a day. A physician's order dated 11/6/24 directed to administer Cholecalciferol (supplement)oral capsule 1.25 mg give 1 capsule orally once a day every 7 days. A physician' order dated 1/15/25 directed to administer Xifaxan (treatment for high ammonia levels) 550 mg tabs give 1 tablet orally twice a day. 6. Resident #31's diagnosis included heart failure, depression and dementia. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 7/4/24 directed to administer Amlodipine besylate tablet 10 mg give 1 tablet orally once a day, Cyanocobalamin (supplement) tablet 1000 micrograms (mcg) give 1 tablet orally once a day, Lipitor oral tablet 10 mg give 10 mg orally once a day, MiraLAX oral packet 17 grams (gm) give 1 packet orally once a day, Multiple vitamins with minerals give 1 tablet orally once a day, Senna (laxative) oral tablet give 8.6 mg orally once a day. A physician's order dated 7/11/24 directed to administer Ferrous sulfate (iron supplement) tablet 2 mg give 1 tablet orally once a day, Folic acid (supplement) oral tablet 1 mg give 1 tablet orally once a day. A physician's order dated 7/13/24 directed to administer Trelegy Ellipta (reduce bronchospasms in asthma/COPD) inhalation aerosol powder breath activated 200-62.5-25 mcg/act 1 puff inhale orally once a day. A physician's order dated 8/28/24 directed to administer Lubiprostone (constipation) oral capsule 24 mcg give 2 mcg orally twice a day. A physician's order dated 10/12/24 directed to administer Singulair (prevents asthma attacks) oral tablet 10mg give 1 tablet orally once a day. A physician's order dated 11/6/24 directed to administer Allegra allergy oral tablet give 180 mg orally once a day for allergies. A physician's order dated 12/19/24 directed to administer Escitalopram oxalate tablet 20 mg give 1 tablet orally once a day. A physician's order dated 1/20/25 directed to administer Prednisone (steroid) oral tablet 10 mg give 1 tablet orally once a day. A physician's order dated 2/3/25 directed to check blood glucose twice a day. A physician's order dated 2/13/25 directed to administer Lasix oral tablet 20 mg give 40 mg orally once a day. A physician's order dated 2/19/25 directed to check blood sugar before meals and at bedtime. A physician's order dated 2/23/25 directed to administer Gabapentin tab 600 mg give 1 tablet oral three times a day, Freestyle Libre 2 reader device apply 1 application trans dermally before meals and at bedtime. Novolog injection solution 100 unit/ml inject 4 units subcutaneously before meals and at bedtime, Novolog injection solution 100 unit/ml as per sliding scale if 150-199 give 4 units, 200-249 give 6 units, 250-299 give 8 units, 300-349 give 10 units, 350-399 give 12 units, 400-449 give 14 units, 450-499 give 16 units, 500 give 20 units and notify the provider before meals and at bedtime. A physician's order dated 2/24/25 directed to administer Metformin HCL oral tablet 500 mg Give 1 tablet orally twice a day. A physician's order dated 2/26/25 directed to administer Trazadone (antidepressant) HCL oral tablet 50 mg give 25 mg orally once a day. A physician's order dated 3/5/25 directed to administer Oxycodone HCL oral tablet 5 mg give 0.5 tablet orally twice a day. A physician's order dated 3/12/25 directed to administer Protonix (excessive stomach acid) oral tablet delayed release 40 mg give 1 tablet orally twice a day for 8 weeks. 7. Resident # 33's diagnosis included dementia, congestive heart failure and Parkinson's disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 12/18/24 directed to administer Carb/Levo 25mg/100 tab give 2 tablets orally three times a day, Gabapentin 300 mg capsules give 1 capsule orally three times a day. A physician's order dated 12/28/24 directed to administer pantoprazole 40 mg tablets give 1 tablet orally twice a day. A physician's order dated 12/19/24 directed to administer Sertraline 100 mg tabs give 1 tablet orally once a day, aspirin low tab 8 mg give 1 tablet orally once a day, Clopidogrel tab 75 mg give 1 tablet orally once a day, Seroquel oral tablet 25 mg give 1 tablet orally once a day, A physician's order dated 1/28/25 directed to administer Amlodipine tab 10 mg Give 1 tablet orally once a day, Lisinopril tab 40 mg give 1 tablet orally once a day, Carvedilol 6.25 mg tab give 2 tablets orally twice a day, A physician's order dated 1/30/25 directed to administer Lantus subcutaneous solution 100 units/ml inject 40 units subcutaneously once a day. A physician's order dated 2/13/25 directed to administer Primidone tab 50 mg Give 0.5 tablet orally twice a day. Trazadone 50 mg tabs give 25 mg orally twice a day. A physician's order dated 2/14/25 directed to administer Humalog Kwik pen subcutaneous solution 100units/ml inject 5 units subcutaneously before meals. A physician's order dated 2/28/25 directed to administer Isosorbide Mononitrate ER tablet extended release 24-hour 60 mg give 1 tablet orally once a day. A physician's order dated 3/16/25 directed to administer Insulin lisp injection 100/ml per sliding scales if blood sugar is 150-199 give 3 units if less than 70 notify the provider, 200-249 6 units, 250-299 9 units, 300-349 12 units 350-399 15 units, greater than 400 18 units and notify the physician before meals and at bedtime. A physician's order dated 3/24/25 directed to administer Hydralazine HCL 50 mg tablets give 1.5 tablets orally three times a day. 8. Resident # 42's diagnosis included dementia, anxiety and depression. A physician's order dated 6/3/24 directed to administer Amlodipine 5 mg give 1 tablet orally once a day, fluticasone/vilanterol inhaler (steroid/bronchodilator for treatment of COPD) 100/25/60 1 puff inhale orally once a day, Divalproex (antiseizure) tab 250 mg DR give 250 mg orally twice a day, Guaifenesin (expectorant) tab 400 mg give 1 tab twice a day, omeprazole tab 20 mg give 1 tab twice a day, omeprazole tab 20 mg give 1 tablet orally twice a day. A physician's order dated 8/13/24 directed to administer Tylenol extra strength oral tablet 500 mg give 1000mg orally twice a day. A physician's order dated 3/2025 directed to administer Escitalopram 5 mg tablet give 20 mg orally once a day, 9. Resident # 45's diagnosis included dementia, diabetes and seizures. A physician's order dated 5/30/24 directed to monitor glucose with Freestyle Libre device check resting blood sugar before meals and at bedtime. A physician's order dated 1/18/25 directed to administer Aspirin low 81 mg give 1 tablet orally once a day, Calcium citrate tab 200 mg give 1 tablet orally once a day, Polyether glycol powder 3350 NF give 17(Gram) gm orally once a day, Primidone tab 50 mg give 1 tablet orally every 12 hours, Tab a vit tab give 1 tablet orally once a day, Tresiba Flex injection 100 unit inject 12 units subcutaneously once a day, Vitamin C 500 mg tabs give 1 tablet orally once a day, Lexapro oral tablet 5 mg give 1 tablet orally once a day, Novolog flex pen subcutaneous solution pen injector 100 unit/ml inject 4 units subcutaneously once a day, Tamsulosin 0.4 mg caps give 1 capsule orally twice a day. A physician's order dated 1/20/25 directed to administer Sodium Bicarbonate (antacid) oral tablet 650 mg give 1 tablet orally twice a day, Sodium chloride oral tablet 1 gm give 1 tablet orally twice a day. A physician's order dated 1/29/25 directed to administer Norvasc oral tablet 5 mg give 1 tablet orally once a day, Coreg oral tablet 12.5 mg give 12.5 mg orally twice a day hold for systolic blood pressure less than 100 or heart rate less than 55 and notify physician, Hydralazine HCL oral tablet give 15 mg orally three times a day. 10. Resident #49's diagnosis included dementia, diabetes, and chronic kidney disease. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 8/22/24 directed to administer Tetrahydrozoline-dextran-polyethylene glycol povidone (eye irritation) eye drops instill 2 drops in left eye twice a day, Preparation H (hemorrhoid relief) rectal suppository insert 1 suppository rectally twice a day. A physician's order dated 8/23/24 directed to administer Citalopram Hydrobromide oral tablet 10 mg give 1 tablet orally once a day, Cyanocobalamin tablet 1000mcg give 2 tablets orally once a day, Folic acid oral tablet 1 mg give 1 tablet orally once a day, Lidocaine HCL external patch 4 % apply to lower back topically once a day, Lisinopril oral tablet 2.5 mg give 1 tablet orally once a day hold for systolic blood pressure less than 90 or diastolic blood pressure less than 60 and notify the physician, Pravastatin sodium oral tablet 20 mg give 1 tablet orally once a day, PreserVision AREDS (supplement) 2 oral capsule with minerals give 1 tablet orally once a day, Vitamin D3 oral tablet 25 mcg give 1 tablet orally once a day. A physician's order dated 8/30/24 directed to administer Lasix oral tablet 20 mg give 1 tablet orally every Monday, Wednesday and Friday, Tylenol oral tablet 325 mg give 2 tablets twice a day. A physician's order dated 10/1/24 directed to administer Ferrous Sulfate oral tablet 325 mg give 325 mg orally one a day. A physician's order dated 2/6/25 directed to administer Eliquis oral tablet 5 mg give 1 tablet orally twice a day. 11. Resident # 56's diagnosis included Alzheimer's disease, anxiety and depression. A physician's order dated 6/3/24 directed to administer Tab a Vite tab give 1 tablet orally once a day, 12. Resident # 59's diagnosis included dementia, congestive heart failure and anxiety disorder. A physician's order dated 6/26/24 directed to administer Cyanocobalamin oral tablet 1000 mg give 1 tablet orally once a day, folic acid oral tablet 1 mg give 1 tablet orally once a day, Lactulose (laxative)oral solution 20 gm/30 ml give 30 ml orally once a day, MiraLAX oral packet 17 gm give 17 gm orally once a day, multivitamin oral tablet give 1 tablet orally once a day, Thiamine HCL oral tablet 100 mg give 1 tablet orally once a day. A physician's order dated 10/8/24 directed to administer Lasix oral tablet 20 mg give 1 tablet orally once a day. A physician's order dated 11/23/24 directed to administer Prozac (antidepressant) oral capsule 10 mg give 10 mg orally once a day. A physician's order dated 1/13/25 directed to administer Potassium chloride ER oral tablet 20 mEq give 1 tablet orally once a day. A physician's order dated 1/16/25 directed to administer Risperdal oral tablet 0.5 mg give 0.25 mg orally once a day. 13. Resident #61's diagnosis included Diabetes, Dementia and Cerebral infarction. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 5/28/24 directed to administer Gabapentin cap 100 mg give 1 capsule twice a day, Metoprolol Tar tablet 50 mg give 1 tablet orally twice a day. A physician's order dated 6/3/24 directed to administer Aspirin low tab 81 mg give 1 tablet once a day, Escitalopram 10 mg tabs give 1 tablet once a day, Ezetimibe (lowers cholesterol) tab 10 mg give 1 tab orally once a day, fluticasone vilanterol inhaler 200/25 60 inhaler 1 inhalation orally once a day, Oxybutynin tab 15 mg ER give 1 tablet orally once a day, Pantoprazole 40 mg tabs give 1 tablet orally once a day, Rosuvastatin (lowers lipids) tab 40 mg give 1 tablet orally once a day, Acidophilus (probiotic) oral capsule give 1 capsule orally once a day, Eliquis 2.5 mg tabs give 1 tablet orally twice a day, Metformin tab 1000mg give 1 tablet orally twice a day. A physician's order dated 9/26/24 directed to administer Cholestyramine (lowers cholesterol) powder 4 gm lite give 4 grams orally once a day. A physician's order dated 3/12/25 directed to administer Trulicity subcutaneous solution autoinjector 0.75 mg/0.5 ml inject 1 syringe subcutaneously once a day every Wednesday. Humalog Kwik pen subcutaneous solution pen injector 1unit/ml inject 2 units subcutaneously before meals. Fasting blood sugar check before meals and at bedtime. Humalog 100 units/ml Kwik pen 3ml inject as per sliding scale if blood sugar is 100-199 give 10 units call physician if glucose is less than 70, 200-400 give 15 units call physician if blood sugar is greater than 400 subcutaneously before meals and at bedtime. 14. Resident #63's diagnosis included Alzheimer's dementia, diabetes, and cerebral infarction. A physician's order dated 6/3/24 directed to administer Aspirin low tab 81 mg give 1 tablet orally once a day, Donepezil 10 mg tabs give 1 tablet orally once a day, Escitalopram 10gm tabs give 1 tablet orally once a day, Tab a Vite tab give 1 tablet once a day, Vitamin B1 tab 100mg give 2 tablets orally once a day, Midodrine tab 5 mg give 1 tablet orally twice a day, Reguloid (fiber) powder orange give 2 tablespoons orally twice a day. A physician's order dated 6/4/24 directed to administer Cholecalciferol oral tablet give 25 mcg orally once a day. A physician's order dated 8/20/24 directed to administer Acetaminophen oral tablet 325 mg give 2 tablets orally three times a day. A physician's order dated 12/6/24 directed to administer Tramadol HCL oral tablet 25 mg give 1 tablet orally twice a day. 15. Resident #67's diagnosis included dementia, hypothyroidism, and chronic kidney disease. A Physician's order dated 6/3/24 directed to administer Allopurinol (gout) tab 100 mg give 1 tablet orally once a day, Amlodipine tab 10 mg give 1 tablet orally once a day, Eliquis 2.5 mg tabs give 1 tablet orally twice a day, Hydralazine tab 25 mg give 1 tablet orally twice a day, Acetaminophen 500 mg tabs give 2 tablets orally three times a day. A physician's order dated 7/31/24 directed to administer Vitamin B12 oral tablet give 1000 mcg orally once a day. A physician's order dated 12/18/24 directed to administer Trazadone 50 mg tabs give 0.5 tablet orally twice a day. 16. Resident # 68's diagnosis included Alzheimer's dementia, depression and hyperkalemia. A physician's order dated 6/3/24 directed to administer Vitamin D 1000 IU caps give 1 capsule orally once a day, Amlodipine besylate tablet 10 mg give 1 tablet orally once a day, Lisinopril tab 40 mg give 1 tablet orally once a day. A physician's order dated 11/2/24 directed to administer Trazadone HCL oral tablet 50 mg give 25 mg orally three times a day. A physician's order dated 12/19/24 directed to administer Escitalopram oxalate oral tablet 20 mg give 1 tablet orally once a day. A physician's order dated 1/18/25 directed to administer Aspirin EC tablet delayed release 81 mg give 1 tablet orally once a day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	17. Resident # 69's diagnosis included dementia, psychotic disorder with delusions, and chronic kidney disorder. A physician's order dated 6/3/24 directed to administer Amlodipine tab 10 mg give 1 tablet orally once a day, Aspirin low 81 mg give 1 tablet orally once a day, Ondansetron (nausea and vomiting) tab 4 mg give 1 tablet orally once a day, Potassium chloride cap 10 mEq ER give 2 capsules once a day, Sertraline 100 mg tabs give 1 tablet orally once a day as part of 125 mg dose in am, Sertraline 25 mg tabs give 1 tablet once a day as part of 125 mg dose in am, Multivitamin with minerals oral tablet give 1 tablet orally once a day, Calcium carb 500 mg tab give 1 tablet orally twice a day, Vitamin C 500 mg tab give 2 tablets orally twice a day. 18. Resident #72's diagnosis included dementia, hypothyroidism, and anxiety disorder. A physician's order dated 6/3/24 directed to administer Famotidine 10 mg tabs give 2 tablets orally once a day, Valsartan tab 160 mg give 1 tablet orally once a day, Vitamin D 3 50000 IU caps give 1 capsule orally once a day, Hydralazine tab 10 mg Give 1 tablet orally three times a day, A physician's order dated 6/20/24 directed to administer Aspirin tablet 81 mg give 1 tablet orally once a day. A physician's order dated 3/4/25 directed to administer Sodium Chloride oral tablet 1 gm give 1 tablet orally twice a day. 19. Resident # 74's diagnosis included Alzheimer's dementia, hypokalemia, and hypothyroidism. A physician's order dated 6/3/24 directed to administer Escitalopram 10 mg tabs give 1 tablet orally once a day, Lisinopril 10 mg tabs give 1 tablet orally once a day, Memantine 5 mg tabs give 1 tablet orally twice a day. A physician's order dated 1/17/25 directed to administer Vitamin B 12 oral tablet 100 mcg give 1 tablet orally once a day. 20. Resident # 78's diagnosis included Alzheimer's Dementia, hypothyroidism, and anxiety disorder. A physician's order dated 6/3/24 directed to administer Docusate sodium cap 100 mg give 1 capsule orally twice a day, Meloxicam tab 15 mg give 1 tablet orally once a day, Potassium chloride solution 10% give 15 ml orally once a day, Acetaminophen 500 mg tabs give 2 tablets orally twice a day, genteal tear (dry eyes) solution instill 2 drops in left eye twice a day. A physician's order dated 7/16/24 directed to administer Lisinopril tablet 2.5 mg give 1 tablet orally once a day. A physician's order dated 1/24/25 directed to administer Multiple vitamins with minerals give 1 tablet orally once a day. A physician's order dated 3/16/25 directed to administer Combigan (glaucoma) 0.2-0.5% ophthalmic solution instill 1 drop in both eyes twice a day. 21. Resident # 81's diagnosis included dementia, anxiety and depression. A physician's order dated 6/3/24 directed to administer Amlodipine 2.5 mg tabs give 1 tablet orally once a day, Atenolol 25 mg tabs give 0.5 tablet orally once a day, Memantine tab 10 mg give 1 tablet orally twice a day, Senna 8.6 mg tabs give 2 tablets orally once a day. 22. Resident #92's diagnosis included Paranoid schizophrenia, hypokalemia and anxiety disorder. (continued on next page)

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New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 6/19/24 directed to administer Amlodipine besylate oral tablet 5 mg give 1 tablet orally once a day. A physician's order dated 7/27/24 directed to administer Oyster shell calcium oral tablet 500mg give 1 tablet orally once a day. A physician's order dated 12/4/24 directed to administer Trazadone HCL oral tablet 50 mg give 0.5 tablet orally twice a day. Observations on 3/26/25 at 10:30 AM, identified Licensed Practical Nurse (LPN) #6 was having difficulty accessing Point Click Care (PCC) the electronic medical record system (EMAR). LPN #6 was heard to state I can't get into these computers, I don't know what is wrong with these computers, I have not been able to get into PCC all morning. I hate these computers, I wish we just went back to paper. Interview with LPN #6 on 3/26/25 at 10:30 AM identified she was unable to access PCC since the start of her shift at 7:00 AM. She stated she had tried 2 laptops and 2 desktop computers unsuccessfully. LPN #6 indicated she had administered medications to the 22 residents on her assignment, for the morning medication pass by memory, without the benefit of the use of a Medication Administration Record (MAR). (An MAR ensures the 5 rights of medication administration, right patient, right drug, right dose, right route, and right time). LPN #6 stated that she had failed to document any of the non-narcotic medications that she had administered by any alternate means of record keeping. LPN #6 was able to show a written record of each of the residents who received narcotics as narcotic medications required a signature in the narcotic book, on the proof of use sheet, that the medication had been signed out for a specific resident. Additionally, LPN #6 identified she had failed to notify a supervisor or the Assistant Director of Nursing (ADNS) when she was unable to access the EMAR or the software used for medication administration, PCC, because she wanted to get the medications passed and planned on documenting what she had given after the medication pass was completed. LPN #6 indicated that if any resident medications had changed since her last shift, she would have expected the off-going nurse to communicate this verbally, during a nurse-to-nurse report, for each of the residents who may have had changes. LPN # 6 further indicated that it was not an appropriate practice to administer medications to residents without utilizing an MAR, and that the policy was to call a supervisor when locked out of the EMAR and PCC. Interview on 3/26/25 at 11:00 AM with the Assistant Director of Nursing Services (ADNS) identified that she was not made aware LPN #6 was unable to access the EMAR or PCC and had not received any communication from LPN #6 to reset her password. The ADNS stated that LPN #6 had passed medications to 22 residents without the benefit of an MAR and should have contacted the supervisor or herself to reset her password. The ADNS identified it was inappropriate and against the policy to administer medications without the benefit of utilizing the MAR to ensure the 5 rights of medication administration were performed. The ADNS was unable to explain why LPN #6 would administer medications to 22 residents, by memory, without utilizing an MAR. Interview with the Corporate Regional Nurse, Registered Nurse (RN) #4 on 3/26/25 at 11:26 AM identified that the physician, Advanced Practice Registered Nurse (APRN), and responsible parties had been notified of LPN #6's inappropriate use of memory to administer medications to 22 residents, without the benefit of utilizing an MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with APRN #1 on 3/26/25 at 12:22 PM identified she was made aware that 22 residents were administered medications by LPN #6, by memory, without the benefit of an MAR, and that she had reviewed all of the medications ordered for the affected residents under her care. APRN #1 stated that for the residents who required blood sugar monitoring, she had ordered blood sugar checks immediately and to continue per the established schedule. All affected residents were to have vital sign checks every shift for 24 hours to monitor their health status. APRN #1 additionally ordered labs to be checked for the residents who were receiving sodium chloride tablets and that she was to be notified of any abnormalities. Interview with APRN #2 on 3/26/25 at 12:30 PM identified that she was made aware that 22 resident's medications were administered without the benefit of an MAR, by memory, by LPN #6. APRN #2 identified she had just observed all of the residents under her care, would review those resident medications, and would determine if further monitoring would be required. Additionally, APRN #2 identified that she would review the vital signs and blood sugars for her residents and leave orders to be notified for any abnormalities. Review of the charting and documentation policy dated 6/2023 revised, in part, directed that documentation in the medical record may be electronic, manual or a combination. The following information is to be documented in the resident medical record: Objective observations, medication administered, treatment or services performed. Review of the job description for a charge nurse, is that the LPN/RN is responsible for the overall operation and optimal quality of care for the residents on the assigned unit, follows all health, sanitary and infection control policies, and maintains established standards of practice set forth by the facility's administration and nursing policies and procedures. The direct supervisor is the RN supervisor. Qualifications included knowledge of nursing theory and practice including the administration of medications. According to the National Library of Medicine dated 9/4/23 Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical records, facility documentation, facility policy and interviews for 22 of 40 residents (Resident #3, Resident #9, Resident #12, Resident #18, Resident #27, Resident #31, Resident #33, Resident #42, Resident #45, Resident #49, Resident #56, Resident #59, Resident #61, Resident #63, Resident #67, Resident #68, Resident #69, Resident #72, Resident # 74, Resident #78, Resident #81, Resident #92) reviewed during a tour of the secured memory unit, the facility failed to ensure safe medication administration practices during the morning medication pass. These failures resulted in the finding of Immediate Jeopardy. Additionally, based on observations, interviews, review of the clinical record and facility policy for 1 of 3 sampled residents (Resident #52) reviewed for nutrition, the facility failed to conduct reweights according to the facility policy. The findings include: 1. a. Resident #3's diagnoses included severe protein calorie malnutrition, cerebral infarction, and anxiety disorder. A physician's order dated 12/18/24 directed to administer Clopidogrel Bisulfate (antiplatelet) 75 milligrams (mg) orally once a day, Escitalopram Oxalate (antidepressant) 20 mg orally one a day, Multivitamin (supplement) 1 tablet orally once a day, Vitamin B Complex (supplement) 1 capsule orally once a day, Vitamin C (supplement) 1 tablet orally once a day, Vitamin D (supplement) 1 tablet orally once a day. A physician's order dated 1/19/25 directed to administer Aspirin 81 milligrams (mg) chewable orally once a day. A physician's order dated 2/2/25 directed to administer Trazadone 50 mg (antidepressant) orally twice a day, a physician's order dated 3/16/25 directed to administer Bupropion HCL ER (antidepressant extended release) 150 mg orally twice a day. b. Resident #9 diagnosis included Alzheimer's dementia, diabetes, and congestive heart failure. A physician's order dated 8/6/24 directed to administer Memantine HCL (Anti-Alzheimer's) 5 mg orally1 tablet twice a day. A physician's order dated 8/7/24 directed to administer Aspirin 81 mg chewable orally once a day, Furosemide 20 mg (diuretic) 1 tablet orally once a day hold if systolic blood pressure is less than 100, Metformin HCL (antidiabetic) 500 mg 1 tablet orally once a day, Multivitamin 1 tablet orally once a day, Polysaccharide iron complex (supplement) 150 mg 1 capsule orally once a day, Toprol XL (extended release for high blood pressure) 25 mg 1 tablet orally once a day. A physician's order dated 8/9/24 directed Midodrine HCL (elevates blood pressure) 5 mg 1 tablet orally twice a day. A physician's order dated 2/21/25 directed to administer Tylenol extra strength 500 mg 2 tablets orally twice a day, c. Resident #12's diagnosis included Parkinson's disease, dementia and emphysema. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 6/3/24 directed to administer Amlodipine (lowers blood pressure) 2.5 mg 1 tablet orally once a day, Carb/Levo (Parkinson's) 25-100 mg 1 tablet orally three times a day, Polyethylene Glycol powder (constipation) 3350 1 tablet once a day, Rivastigmine dis (Alzheimer's/Parkinson's) 9.5/24 apply 1 patch once a day trans dermally, Alendronate (osteoporosis) 70 mg 1 tablet orally once a day, aspirin chewable 81 mg 1 tablet orally once a day, Calcium /D 600-400 mg (supplement) 1 tablet orally once a day, Memantine 5 mg 1 tablet orally once a day, Vitamin D 1000 international units (IU) 2 caps orally once a day, Acetaminophen (pain) 500 mg 2 tablets orally twice a day, Budes/[NAME] Aer(emphysema) 160-4.5 120 Inh 2 puffs orally twice a day, Celecoxib cp (anti-inflammatory) 100 mg 1 capsule twice a day, Entacapone (Parkinson's) 200 mg 1 tablet orally twice a day. d. Resident #18 diagnosis included Alzheimer's dementia, diabetes, and depression. A physician's order dated 6/3/24 directed to administer Amlodipine 10 mg 1 tablet once a day, Aspirin low 81 mg 1 tablet orally once a day, Escitalopram 10 mg 1 tablet orally once a day, Hydrochlorothiazide (lowers blood pressure) tablet 25mg 1 tablet orally once a day, Losartan (lowers blood pressure) 50 mg 1 tablet orally once a day, Acetaminophen 500 mg tab orally twice a day, Metformin 1000 mg 1 tablet twice a day, Metoprolol Tar (lowers blood pressure) 50 mg 1 tab twice a day, A physician's order dated 10/29/24 directed to administer Potassium Chloride (elevates potassium) Liquid 20 milliequivalent/15 milliliter (meq/ml) 20 met orally twice a day. A physician's order dated 1/14/25 directed Lantus Solostar (antidiabetic) subcutaneous solutions pen injector 100 unit/ml inject 16 units subcutaneously once a day. A physician's order dated 3/6/25 directed to administer Atorvastatin Calcium (lowers cholesterol) 20 mg 1 tablet orally once a day. A physician's order dated 3/7/25 directed to administer Fenofibrate (lowers cholesterol) 145 mg 1 tablet once a day. e. Resident # 27 diagnosis included Dementia, Diabetes, and Epilepsy. A physician's order dated 5/30/24 directed to check blood sugars before meals and at bedtime. A physician's order dated 6/3/24 directed to administer Levetiracetam tabs (antiseizure) 500 mg give 1 tablet orally twice a day, Lisinopril (lowers blood pressure) 5 mg give 1 tablet orally once a day, Metformin tab 1000mg give 1 tablet orally twice a day, Metoprolol Tar 25mg tablet give 0.5 tablet orally twice a day, Risperidone (antipsychotic) 2 mg tabs Give 1 tablet orally twice a day, Insulin lisp injection 100/ml inject per sliding scale if blood sugar is 150 - 199 give 2 units, 200-249 give 3 units, 250-299 give 4 units, 300-349 give 5 units, 350-399 give 6 units, grated than 399 give 8 units and call the physician subcutaneously before meals and at bedtime. A physician's order dated 7/15/24 directed to administer Gabapentin (antiseizure) capsule 300 mg give 1 capsule orally three times a day. A physician's order dated 7/23/24 directed to administer Depakote(antiseizure) oral tablet delayed release 250 mg give 2 tablets orally once a day. A physician's order dated 9/17/24 directed to administer oyster shell (supplement) oral tablet 500 mg give 1 tablet orally once a day. A physician's order dated 9/28/24 directed to administer Celexa (antidepressant) oral tablet 20 mg give 30 mg orally once a day. A physician's order dated 10/16/24 directed Celebrex (non-steroidal anti-inflammatory) oral capsule 100 mg give 1 capsule orally twice a day. A physician's order dated 10/24/24 directed to administer Oxycodone HCL (opioid pain reliever) tablet 5 mg, give 5 mg orally three times a day. A physician's order dated 11/5/24 directed to administer Amantadine (Parkinson's like symptoms) 100 mg caps give 2 capsules orally twice a day. A physician's order dated 11/6/24 directed to administer Cholecalciferol (supplement)oral capsule 1.25 mg give 1 capsule orally once a day every 7 days. A physician' order dated 1/15/25 directed to administer Xifaxan (treatment for high ammonia levels) 550 mg tabs give 1 tablet orally twice a day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	f. Resident #31's diagnosis included heart failure, depression and dementia. A physician's order dated 7/4/24 directed to administer Amlodipine besylate tablet 10 mg give 1 tablet orally once a day, Cyanocobalamin (supplement) tablet 1000 micrograms (mcg) give 1 tablet orally once a day, Lipitor oral tablet 10 mg give 10 mg orally once a day, MiraLAX oral packet 17 grams (gm) give 1 packet orally once a day, Multiple vitamins with minerals give 1 tablet orally once a day, Senna (laxative) oral tablet give 8.6 mg orally once a day. A physician's order dated 7/11/24 directed to administer Ferrous sulfate (iron supplement) tablet 2 mg give 1 tablet orally once a day, Folic acid (supplement) oral tablet 1 mg give 1 tablet orally once a day. A physician's order dated 7/13/24 directed to administer Trelegy Ellipta (reduce bronchospasms in asthma/COPD) inhalation aerosol powder breath activated 200-62.5-25 mcg/act 1 puff inhale orally once a day. A physician's order dated 8/28/24 directed to administer Lubiprostone (constipation) oral capsule 24 mcg give 2 mcg orally twice a day. A physician's order dated 10/12/24 directed to administer Singulair (prevents asthma attacks) oral tablet 10mg give 1 tablet orally once a day. A physician's order dated 11/6/24 directed to administer Allegra allergy oral tablet give 180 mg orally once a day for allergies. A physician's order dated 12/19/24 directed to administer Escitalopram oxalate tablet 20 mg give 1 tablet orally once a day. A physician's order dated 1/20/25 directed to administer Prednisone (steroid) oral tablet 10 mg give 1 tablet orally once a day. A physician's order dated 2/3/25 directed to check blood glucose twice a day. A physician's order dated 2/13/25 directed to administer Lasix oral tablet 20 mg give 40 mg orally once a day. A physician's order dated 2/19/25 directed to check blood sugar before meals and at bedtime. A physician's order dated 2/23/25 directed to administer Gabapentin tab 600 mg give 1 tablet oral three times a day, Freestyle Libre 2 reader device apply 1 application trans dermally before meals and at bedtime. Novolog injection solution 100 unit/ml inject 4 units subcutaneously before meals and at bedtime, Novolog injection solution 100 unit/ml as per sliding scale if 150-199 give 4 units, 200-249 give 6 units, 250-299 give 8 units, 300-349 give 10 units, 350-399 give 12 units, 400-449 give 14 units, 450-499 give 16 units, 500 give 20 units and notify the provider before meals and at bedtime. A physician's order dated 2/24/25 directed to administer Metformin HCL oral tablet 500 mg Give 1 tablet orally twice a day. A physician's order dated 2/26/25 directed to administer Trazadone (antidepressant) HCL oral tablet 50 mg give 25 mg orally once a day. A physician's order dated 3/5/25 directed to administer Oxycodone HCL oral tablet 5 mg give 0.5 tablet orally twice a day. A physician's order dated 3/12/25 directed to administer Protonix (excessive stomach acid) oral tablet delayed release 40 mg give 1 tablet orally twice a day for 8 weeks. g. Resident # 33's diagnosis included dementia, congestive heart failure and Parkinson's disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 12/18/24 directed to administer Carb/Levo 25mg/100 tab give 2 tablets orally three times a day, Gabapentin 300 mg capsules give 1 capsule orally three times a day. A physician's order dated 12/28/24 directed to administer pantoprazole 40 mg tablets give 1 tablet orally twice a day. A physician's order dated 12/19/24 directed to administer Sertraline 100 mg tabs give 1 tablet orally once a day, aspirin low tab 8 mg give 1 tablet orally once a day, Clopidogrel tab 75 mg give 1 tablet orally once a day, Seroquel oral tablet 25 mg give 1 tablet orally once a day, A physician's order dated 1/28/25 directed to administer Amlodipine tab 10 mg Give 1 tablet orally once a day, Lisinopril tab 40 mg give 1 tablet orally once a day, Carvedilol 6.25 mg tab give 2 tablets orally twice a day, A physician's order dated 1/30/25 directed to administer Lantus subcutaneous solution 100 units/ml inject 40 units subcutaneously once a day. A physician's order dated 2/13/25 directed to administer Primidone tab 50 mg Give 0.5 tablet orally twice a day. Trazadone 50 mg tabs give 25 mg orally twice a day. A physician's order dated 2/14/25 directed to administer Humalog Kwik pen subcutaneous solution 100units/ml inject 5 units subcutaneously before meals. A physician's order dated 2/28/25 directed to administer Isosorbide Mononitrate ER tablet extended release 24-hour 60 mg give 1 tablet orally once a day. A physician's order dated 3/16/25 directed to administer Insulin lisp injection 100/ml per sliding scales if blood sugar is 150-199 give 3 units if less than 70 notify the provider, 200-249 6 units, 250-299 9 units, 300-349 12 units 350-399 15 units, greater than 400 18 units and notify the physician before meals and at bedtime. A physician's order dated 3/24/25 directed to administer Hydralazine HCL 50 mg tablets give 1.5 tablets orally three times a day. h. Resident # 42's diagnosis included dementia, anxiety and depression. A physician's order dated 6/3/24 directed to administer Amlodipine 5 mg give 1 tablet orally once a day, fluticasone/vilanterol inhaler (steroid/bronchodilator for treatment of COPD) 100/25/60 1 puff inhale orally once a day, Divalproex (antiseizure) tab 250 mg DR give 250 mg orally twice a day, Guaifenesin (expectorant) tab 400 mg give 1 tab twice a day, omeprazole tab 20 mg give 1 tab twice a day, omeprazole tab 20 mg give 1 tablet orally twice a day. A physician's order dated 8/13/24 directed to administer Tylenol extra strength oral tablet 500 mg give 1000mg orally twice a day. A physician's order dated 3/2025 directed to administer Escitalopram 5 mg tablet give 20 mg orally once a day, i. Resident # 45's diagnosis included dementia, diabetes and seizures. A physician's order dated 5/30/24 directed to monitor glucose with Freestyle Libre device check resting blood sugar before meals and at bedtime. A physician's order dated 1/18/25 directed to administer Aspirin low 81 mg give 1 tablet orally once a day, Calcium citrate tab 200 mg give 1 tablet orally once a day, Polyether glycol powder 3350 NF give 17(Gram) gm orally once a day, Primidone tab 50 mg give 1 tablet orally every 12 hours, Tab a vit tab give 1 tablet orally once a day, Tresiba Flex injection 100 unit inject 12 units subcutaneously once a day, Vitamin C 500 mg tabs give 1 tablet orally once a day, Lexapro oral tablet 5 mg give 1 tablet orally once a day, Novolog flex pen subcutaneous solution pen injector 100 unit/ml inject 4 units subcutaneously once a day, Tamsulosin 0.4 mg caps give 1 capsule orally twice a day. A physician's order dated 1/20/25 directed to administer Sodium Bicarbonate (antacid) oral tablet 650 mg give 1 tablet orally twice a day, Sodium chloride oral tablet 1 gm give 1 tablet orally twice a day. A physician's order dated 1/29/25 directed to administer Norvasc oral tablet 5 mg give 1 tablet orally once a day, Coreg oral tablet 12.5 mg give 12.5 mg orally twice a day hold for systolic blood pressure less than 100 or heart rate less than 55 and notify physician, Hydralazine HCL oral tablet give 15 mg orally three times a day. j. Resident #49's diagnosis included dementia, diabetes, and chronic kidney disease. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 8/22/24 directed to administer Tetrahydrozoline-dextran-polyethylene glycol povidone (eye irritation) eye drops instill 2 drops in left eye twice a day, Preparation H (hemorrhoid relief) rectal suppository insert 1 suppository rectally twice a day. A physician's order dated 8/23/24 directed to administer Citalopram Hydrobromide oral tablet 10 mg give 1 tablet orally once a day, Cyanocobalamin tablet 1000mcg give 2 tablets orally once a day, Folic acid oral tablet 1 mg give 1 tablet orally once a day, Lidocaine HCL external patch 4 % apply to lower back topically once a day, Lisinopril oral tablet 2.5 mg give 1 tablet orally once a day hold for systolic blood pressure less than 90 or diastolic blood pressure less than 60 and notify the physician, Pravastatin sodium oral tablet 20 mg give 1 tablet orally once a day, PreserVision AREDS (supplement) 2 oral capsule with minerals give 1 tablet orally once a day, Vitamin D3 oral tablet 25 mcg give 1 tablet orally once a day. A physician's order dated 8/30/24 directed to administer Lasix oral tablet 20 mg give 1 tablet orally every Monday, Wednesday and Friday, Tylenol oral tablet 325 mg give 2 tablets twice a day. A physician's order dated 10/1/24 directed to administer Ferrous Sulfate oral tablet 325 mg give 325 mg orally one a day. A physician's order dated 2/6/25 directed to administer Eliquis oral tablet 5 mg give 1 tablet orally twice a day. k. Resident # 56's diagnosis included Alzheimer's disease, anxiety and depression. A physician's order dated 6/3/24 directed to administer Tab a Vite tab give 1 tablet orally once a day, l. Resident # 59's diagnosis included dementia, congestive heart failure and anxiety disorder. A physician's order dated 6/26/24 directed to administer Cyanocobalamin oral tablet 1000 mg give 1 tablet orally once a day, folic acid oral tablet 1 mg give 1 tablet orally once a day, Lactulose (laxative)oral solution 20 gm/30 ml give 30 ml orally once a day, MiraLAX oral packet 17 gm give 17 gm orally once a day, multivitamin oral tablet give 1 tablet orally once a day, Thiamine HCL oral tablet 100 mg give 1 tablet orally once a day. A physician's order dated 10/8/24 directed to administer Lasix oral tablet 20 mg give 1 tablet orally once a day. A physician's order dated 11/23/24 directed to administer Prozac (antidepressant) oral capsule 10 mg give 10 mg orally once a day. A physician's order dated 1/13/25 directed to administer Potassium chloride ER oral tablet 20 mEq give 1 tablet orally once a day. A physician's order dated 1/16/25 directed to administer Risperdal oral tablet 0.5 mg give 0.25 mg orally once a day. m. Resident #61's diagnosis included Diabetes, Dementia and Cerebral infarction. (continued on next page)

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New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 5/28/24 directed to administer Gabapentin cap 100 mg give 1 capsule twice a day, Metoprolol Tar tablet 50 mg give 1 tablet orally twice a day. A physician's order dated 6/3/24 directed to administer Aspirin low tab 81 mg give 1 tablet once a day, Escitalopram 10 mg tabs give 1 tablet once a day, Ezetimibe (lowers cholesterol) tab 10 mg give 1 tab orally once a day, fluticasone vilanterol inhaler 200/25 60 inhaler 1 inhalation orally once a day, Oxybutynin tab 15 mg ER give 1 tablet orally once a day, Pantoprazole 40 mg tabs give 1 tablet orally once a day, Rosuvastatin (lowers lipids) tab 40 mg give 1 tablet orally once a day, Acidophilus (probiotic) oral capsule give 1 capsule orally once a day, Eliquis 2.5 mg tabs give 1 tablet orally twice a day, Metformin tab 1000mg give 1 tablet orally twice a day. A physician's order dated 9/26/24 directed to administer Cholestyram (lowers cholesterol) powder 4 gm lite give 4 grams orally once a day. A physician's order dated 3/12/25 directed to administer Trulicity subcutaneous solution autoinjector 0.75 mg/0.5 ml inject 1 syringe subcutaneously once a day every Wednesday. Humalog Kwik pen subcutaneous solution pen injector 1unit/ml inject 2 units subcutaneously before meals. Fasting blood sugar check before meals and at bedtime. Humalog 100 units/ml Kwik pen 3ml inject as per sliding scale if blood sugar is 100-199 give 10 units call physician if glucose is less than 70, 200-400 give 15 units call physician if blood sugar is greater than 400 subcutaneously before meals and at bedtime. n. Resident #63's diagnosis included Alzheimer's dementia, diabetes, and cerebral infarction. A physician's order dated 6/3/24 directed to administer Aspirin low tab 81 mg give 1 tablet orally once a day, Donepezil 10 mg tabs give 1 tablet orally once a day, Escitalopram 10gm tabs give 1 tablet orally once a day, Tab a Vite tab give 1 tablet once a day, Vitamin B1 tab 100mg give 2 tablets orally once a day, Midodrine tab 5 mg give 1 tablet orally twice a day, Reguloid (fiber) powder orange give 2 tablespoons orally twice a day. A physician's order dated 6/4/24 directed to administer Cholecalciferol oral tablet give 25 mcg orally once a day. A physician's order dated 8/20/24 directed to administer Acetaminophen oral tablet 325 mg give 2 tablets orally three times a day. A physician's order dated 12/6/24 directed to administer Tramadol HCL oral tablet 25 mg give 1 tablet orally twice a day. o. Resident #67's diagnosis included dementia, hypothyroidism, and chronic kidney disease. A Physician's order dated 6/3/24 directed to administer Allopurinol (gout) tab 100 mg give 1 tablet orally once a day, Amlodipine tab 10 mg give 1 tablet orally once a day, Eliquis 2.5 mg tabs give 1 tablet orally twice a day, Hydralazine tab 25 mg give 1 tablet orally twice a day, Acetaminophen 500 mg tabs give 2 tablets orally three times a day. A physician's order dated 7/31/24 directed to administer Vitamin B12 oral tablet give 1000 mcg orally once a day. A physician's order dated 12/18/24 directed to administer Trazadone 50 mg tabs give 0.5 tablet orally twice a day. p. Resident # 68's diagnosis included Alzheimer's dementia, depression and hyperkalemia. A physician's order dated 6/3/24 directed to administer Vitamin D 1000 IU caps give 1 capsule orally once a day, Amlodipine besylate tablet 10 mg give 1 tablet orally once a day, Lisinopril tab 40 mg give 1 tablet orally once a day. A physician's order dated 11/2/24 directed to administer Trazadone HCL oral tablet 50 mg give 25 mg orally three times a day. A physician's order dated 12/19/24 directed to administer Escitalopram oxalate oral tablet 20 mg give 1 tablet orally once a day. A physician's order dated 1/18/25 directed to administer Aspirin EC tablet delayed release 81 mg give 1 tablet orally once a day. (continued on next page)

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New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	q. Resident # 69's diagnosis included dementia, psychotic disorder with delusions, and chronic kidney disorder. A physician's order dated 6/3/24 directed to administer Amlodipine tab 10 mg give 1 tablet orally once a day, Aspirin low 81 mg give 1 tablet orally once a day, Ondansetron (nausea and vomiting) tab 4 mg give 1 tablet orally once a day, Potassium chloride cap 10 mEq ER give 2 capsules once a day, Sertraline 100 mg tabs give 1 tablet orally once a day as part of 125 mg dose in am, Sertraline 25 mg tabs give 1 tablet once a day as part of 125 mg dose in am, Multivitamin with minerals oral tablet give 1 tablet orally once a day, Calcium carb 500 mg tab give 1 tablet orally twice a day, Vitamin C 500 mg tab give 2 tablets orally twice a day. r. Resident #72's diagnosis included dementia, hypothyroidism, and anxiety disorder. A physician's order dated 6/3/24 directed to administer Famotidine 10 mg tabs give 2 tablets orally once a day, Valsartan tab 160 mg give 1 tablet orally once a day, Vitamin D 3 50000 IU caps give 1 capsule orally once a day, Hydralazine tab 10 mg Give 1 tablet orally three times a day, A physician's order dated 6/20/24 directed to administer Aspirin tablet 81 mg give 1 tablet orally once a day. A physician's order dated 3/4/25 directed to administer Sodium Chloride oral tablet 1 gm give 1 tablet orally twice a day. s. Resident # 74's diagnosis included Alzheimer's dementia, hypokalemia, and hypothyroidism. A physician's order dated 6/3/24 directed to administer Escitalopram 10 mg tabs give 1 tablet orally once a day, Lisinopril 10 mg tabs give 1 tablet orally once a day, Memantine 5 mg tabs give 1 tablet orally twice a day. A physician's order dated 1/17/25 directed to administer Vitamin B 12 oral tablet 100 mcg give 1 tablet orally once a day. t. Resident # 78's diagnosis included Alzheimer's Dementia, hypothyroidism, and anxiety disorder. A physician's order dated 6/3/24 directed to administer Docusate sodium cap 100 mg give 1 capsule orally twice a day, Meloxicam tab 15 mg give 1 tablet orally once a day, Potassium chloride solution 10% give 15 ml orally once a day, Acetaminophen 500 mg tabs give 2 tablets orally twice a day, Genteal tear (dry eyes) solution instill 2 drops in left eye twice a day. A physician's order dated 7/16/24 directed to administer Lisinopril tablet 2.5 mg give 1 tablet orally once a day. A physician's order dated 1/24/25 directed to administer Multiple vitamins with minerals give 1 tablet orally once a day. A physician's order dated 3/16/25 directed to administer Combigan (glaucoma) 0.2-0.5% ophthalmic solution instill 1 drop in both eyes twice a day. u. Resident # 81's diagnosis included dementia, anxiety and depression. A physician's order dated 6/3/24 directed to administer Amlodipine 2.5 mg tabs give 1 tablet orally once a day, Atenolol 25 mg tabs give 0.5 tablet orally once a day, Memantine tab 10 mg give 1 tablet orally twice a day, Senna 8.6 mg tabs give 2 tablets orally once a day. v. Resident #92's diagnosis included Paranoid schizophrenia, hypokalemia and anxiety disorder. (continued on next page)

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	075158	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A physician's order dated 6/19/24 directed to administer Amlodipine besylate oral tablet 5 mg give 1 tablet orally once a day. A physician's order dated 7/27/24 directed to administer Oyster shell calcium oral tablet 500mg give 1 tablet orally once a day. A physician's order dated 12/4/24 directed to administer Trazadone HCL oral tablet 50 mg give 0.5 tablet orally twice a day. Observations on 3/26/25 at 10:30 AM, identified Licensed Practical Nurse (LPN) #6 was having difficulty accessing Point Click Care (PCC) the electronic medical record system (EMAR). LPN #6 was heard to state I can't get into these computers, I don't know what is wrong with these computers, I have not been able to get into PCC all morning. I hate these computers, I wish we just went back to paper. Interview with LPN #6 on 3/26/25 at 10:30AM identified she was unable to access PCC since the start of her shift at 7:00 AM. She stated she had tried 2 laptops and 2 desktop computers unsuccessfully. LPN #6 indicated she had administered medications to the 22 residents on her assignment, for the morning medication pass by memory, without the benefit of the use of a Medication Administration Record (MAR). (An MAR ensures the 5 rights of medication administration, right patient, right drug, right dose, right route, and right time). LPN #6 stated that she had failed to document any of the non-narcotic medications that she had administered by any alternate means of record keeping. LPN #6 was able to show a written record of each of the residents who received narcotics as narcotic medications required a signature in the narcotic book, on the proof of use sheet, that the medication had been signed out for a specific resident. Additionally, LPN #6 identified she had failed to notify a supervisor or the Assistant Director of Nursing (ADNS) when she was unable to access the EMAR or the software used for medication administration, PCC, because she wanted to get the medications passed and planned on documenting what she had given after the medication pass was completed. LPN #6 indicated that if any resident medications had changed, she would have expected the off-going nurse to communicate this verbally, during a nurse-to-nurse report, for the resident medications that changed . LPN #6 further indicated that it was not an appropriate practice to administer medications to residents without utilizing an MAR, and that the policy was to call a supervisor when locked out of the EMAR and PCC. Interview on 3/26/25 at 11:00 AM with the Assistant Director of Nursing Services (ADNS) identified that she was not made aware LPN #6 was unable to access the EMAR or PCC and had not received any communication from LPN #6 to reset her password. The ADNS stated that LPN #6 had passed medications to 22 residents without the benefit of an MAR and should have contacted the supervisor or herself to reset her password. The ADNS identified it was inappropriate and against the policy to administer medications without the benefit of utilizing the MAR to ensure the 5 rights of medication administration were performed. Further, the ADNS was unable to explain why LPN #6 would administer medications to 22 residents, by memory, without utilizing an MAR. Interview with the Corporate Regional Nurse, Registered Nurse (RN) #4 on 3/26/25 at 11:26 AM identified that the physician, Advanced Practice Registered Nurse (APRN), and responsible parties had been notified of LPN #6's inappropriate use of memory to administer medications to 22 residents without the benefit of utilizing an MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with APRN #1 on 3/26/25 at 12:22 PM identified she was made aware that 22 residents were administered medications by LPN #6, by memory, without the benefit of an MAR, and that she had reviewed all of the medications ordered for the affected residents under her care. APRN #1 stated that for the residents who required blood sugar monitoring, she had ordered blood sugar checks immediately and to continue per the established schedule. All affected residents were to have vital sign checks every shift for 24 hours to monitor their health status. APRN #1 additionally ordered labs to be checked for the residents who were receiving sodium chloride tablets and that she was to be notified of any abnormalities. Interview with APRN #2 on 3/26/25 at 12:30 PM identified that she was made aware that 22 resident's medications were administered without the benefit of an MAR, by memory, by LPN #6. APRN #2 identified she had just observed all of the residents under her care, would review those resident medications, and would determine if further monitoring would be required. Additionally, APRN #2 identified that she would review the vital signs and blood sugars for her residents and leave orders to be notified for any abnormalities. Review of the policy Electronic Medication Administration Record (EMAR) revised 6/2023 directed the licensed nurse will read the physician order and complete the 5 checks, administer the medication as ordered and document the administration in the EMAR. Although requested, the facility failed to provide a policy for MAR utilization. 2. Resident #52 had a diagnosis that included dementia, anxiety, heart failure and chronic atrial fibrillation (an irregular and rapid heartrate resulting in poor blood flow). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required set up assistance for eating, maximum assistance for personal hygiene, and was dependent on toileting and supervision/touching assistance for bed mobility and transfers. The Resident Care Plan (RCP) dated 10/7/24 identified Resident #52 was at risk for alteration in cardiovascular status related to congestive heart failure (CHF) and atrial fibrillation (an irregular and rapid heartrate resulting in poor blood flow). Interventions included a diet consult as necessary, monitoring/documenting and reporting any changes in lung sounds on auscultation, edema, and changes in weight. A physician's order dated 10/21/24 directed to obtain weekly weights every Wednesday and notify the supervisor if the resident refused. Review of the Weights and Vitals Summary identified Resident #52's weights as: Date Weight (Lbs.) Discrepancy (Lbs.) 10/21/24 222.0 0 10/23/24 222.0 0 10/30/24 220.0 -2 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	11/6/24 220.8 +0.8 11/13/24 229.6 +8.8 11/18/24 228.6 -1 11/20/24 229.0 +1.6 11/27/24 230.0 +1 11/27/24 223.8 -6.2 12/4/24 223.2 -0.6 12/11/24 220.6 -2.6 12/18/24 228.0 +7.4 1/1/25 226.1 -2.1 1/8/25 225.2 -0.9 1/15/25 219.9 -5.3 1/22/25 226.0 +5.9 2/12/25 226.3 -0.3 2/19/25 226.8 +0.5 2/26/25 227.0 +0.2 3/5/25 207.3 19.7 (weight was struck out on 3/17/25 at 9:42 AM by the Dietician stating reweighed) 3/12/25 216.8 +9.5 3/13/25 212.4 -4.4 Review of Resident #52's clinical record from 10/21/24 through 3/17/25, identified no documentation for weight refusals within the progress notes or RCP. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview and record review with LPN #8 on 3/20/25 at 2:30 PM, identified that NA's weigh residents and nurses document the weight in the computer. LPN #8 further stated that the dietician was responsible for monitoring resident weights, communicating weight changes to the provider, and directing reweights. LPN #8 indicated that residents with significant weight changes should be reweighed according to the facility policy and as directed by the dietician. LPN #8 identified that Resident #52 should have been reweighed on 11/13/24 when he/she gained 8.8 pounds (lbs.), on 12/18/24 with a weight increase of 7.4 lbs., on 1/15/25 with a weight decrease of 5.3 lbs., on 1/22/25 with a weight increase of 5.9 lbs., on 3/5/25 with a weight decrease of 19.7 lbs., and on 3/12/25 with a weight increase of 9.5 lbs. LPN #8 could not identify documentation for weight refusals within the progress notes or RCP. Interview and clinical record review with the DNS on 3/20/25 at 3:00 PM, identified that NA's weigh residents and nurses document weights. The DNS stated that the dietician was responsible [TRUNCATED]

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New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, interviews, review of the clinical record, facility documentation, and facility policy for 1 of 3 residents (Resident #4) reviewed for pressure ulcers, the facility failed to turn and reposition a resident with a pressure ulcer according to the physician's order. The findings include: Resident #4's diagnoses included dementia, generalized muscle weakness, anxiety and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment, was dependent on staff for toileting hygiene, personal hygiene, and transfers, and required maximum assistance for bed mobility. The MDS identified that Resident #4 had impairment on both sides of the upper and lower extremities and was always incontinent of urine and bowel. Additionally, the MDS identified that Resident #4 was at risk of developing pressure ulcers and had a pressure reducing device for bed, but did not have a current pressure ulcer. The Resident Care Plan (RCP) in effect for the month of March 2025, identified Resident #4 was at potential/actual impairment to skin integrity related to fragile skin, impaired mobility and incontinence. Interventions included encouraging good nutrition and hydration, following facility protocols for treatment of injury, monitoring/documenting location, size and treatment of skin injury, and reporting abnormalities to the provider. The Resident Care Card in effect for the month of March 2025, identified Resident #4 was non-ambulatory, required the assistance of 2 staff for turning and repositioning every 2 hours, and assistance of 2 staff for mechanical lift transfers. The RCC identified that Resident #4 used wheelchair for mobility and directed Resident #4 to be transferred to an adaptive tilt in space wheelchair up to 8-hour intervals. A Physician' s order in effect for the month of March 2025 directed to turn and reposition Resident #4 at least every 2 hours while in bed. Review of the Integrated Wound Care progress note dated 3/13/25 by Medical Doctor (MD) #2 identified a stage III facility acquired pressure ulcer (PU) to the left heel measuring 4 centimeters (cm.) by 5 cm. by 0 cm. which was described with scant serous (clear, watery fluid from a wound) exudate, 85 percent (%) epithelial tissue (type of body tissue covering internal and external surfaces), positive ecchymosis (skin discoloration that results from bleeding underneath the skin) in the peri wound with no odor present. Observation and interview with Resident #4 on 3/20/25 at 9:00 AM, identified that he/she was lying on his/her back with the head of bed slightly elevated. Resident #4 identified that he/she had not been turned/repositioned and had been lying on his/her back since she woke up. Constant observation on 3/20/25 from 9:00 AM through 11:50 AM identified the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:22 AM, Resident #5 was noted to be lying on his/her back with the head of the bed raised. Registered Nurse (RN) #5 entered Resident #4's room, administered his/her morning medications, and exited without repositioning Resident #4. At 10:00 AM, Resident #5 was noted to be lying on his/her back with the head of the bed raised. Social Worker (SW) #2 entered Resident #4's room and exited room [ROOM NUMBER] minute afterwards without repositioning Resident #4. At 10:30 AM Nurse Aid (NA) #10 and NA#11 were observed providing incontinent care. Resident #26 was left in the same position as prior to the incontinent care, lying on his/her back. At 11:40 AM, Resident #4 remained on his/her back with the head of bed slightly elevated. Interview with NA #10 on 3/20/25 at 11:50 AM, identified that she was not aware Resident #4 needed to be turned and repositioned every 2 hours. NA #10 indicated that resident specific tasks triggered in the task section of the electronic charting system, and she would then sign off the task when performed, but Resident #4 did not have a directive triggered that would alert her to turn and reposition the resident. Further, she stated that she had not turned or repositioned Resident #4 since the beginning of her shift which started at 7:00 AM. NA#10 identified that she was responsible for turning and repositioning Resident #4. Subsequent to surveyors' inquiry Resident #4 was turned and repositioned and was observed lying on his/her right side facing the window at 12:00 PM. Interview and Record review with LPN #8 on 3/20/25 at 2:30 PM identified that NAs were responsible for turning and repositioning residents. LPN #8 identified there was a physician order to turn and reposition Resident #4 every 2 hours. LPN #8 indicated that Resident #4 sometimes refused to be turned and repositioned but identified that she had not attempted to turn and reposition him/her during her shift which began at 7:00AM. LPN #8 was unable to identify a refusal care plan or a progress note indicating that Resident #4 had refused to be turned or repositioned. Interview with the DNS on 3/20/25 at 3:00 PM identified that NA #10 should have checked her care card to determine Resident #10's care and would be re-educated. The DNS further identified that Resident #4 should have been turned and repositioned every 2 hours and any refusals reported to the nurse or nurse supervisor for appropriate interventions to be placed and documentation completed. Review of facility policy titled, Turning and Repositioning Policy, identified in part, the purpose was to promote circulation and relieve pressure from pressure points to maintain skin integrity. Position changes are to be implemented every 2 to 3 hours and when necessary, and if the resident is dependent on staff for mobility, check for toileting needs during repositioning.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, review of the clinical record, facility policy, and interviews for 1 of 2 sampled residents (Resident #39) reviewed for positioning and mobility, the facility failed to ensure a pelvic positioning belt was applied per the physician's order. The findings include: Resident #39's diagnoses included Parkinson's disease, vascular dementia, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #39 was severely cognitively impaired, dependent with toileting, and required partial/moderate assistance with bed mobility and transfers. A Morse fall scale dated 1/20/25 identified Resident #39 had a history of falling and was a high risk for falls. The Resident Care Plan dated 3/3/25 identified Resident #39 was non-ambulatory, required assistance of 1 for transfers, and was a fall risk. Interventions included providing assistive and adaptive devices as ordered and to ensure proper positioning when sitting in a chair. An Occupational Therapy (OT #1) note dated 3/4/25 identified Resident #39 was provided with a seat belt on the wheelchair to improve his/her positioning. The note indicated that Resident #39 demonstrated increased positioning and increased safety with the seatbelt applied. OT #1 note dated 3/12/25 identified Resident #39 was noted with no pelvic positioning belt in place and that caregiver education was provided on the importance of the positioning belt and its benefits. The note indicated Resident #39 demonstrated the ability to doff (remove) the positioning belt with frequent verbal cues. A rehabilitation in-service form dated 3/12/25 identified Resident #39 was to have a pelvic positioning belt for proper body alignment when in his/her manual wheelchair to promote optimal positioning, decrease skin breakdown, and increase safety. The in-service form was signed by staff in attendance and by the in-service provider (OT #1). A physician's order dated 3/17/25 directed Resident #39 was to sit up in the manual wheelchair per tolerance with a pelvic positioning belt applied for proper body alignment. OT #1's note dated 3/18/25 identified continued caregiver education was required for staff on use of the wheelchair pelvic positioning belt for Resident #39. The note indicated that Resident #39 demonstrated good positioning in the wheelchair with the positioning belt in place. Observations on 3/18/25 at 10:06 AM identified Resident #39 was seated in his/her wheelchair in front of the nurse's station without the benefit of having the pelvic positioning belt applied. Observation on 3/18/25 at 11:00 AM identified Resident #39 was seated in his/her wheelchair in the recreation room without the benefit of having the pelvic positioning belt applied. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with NA #4 on 3/19/25 at 11:07 AM identified Resident #39 was seated in his/her room in the wheelchair without the benefit of having the pelvic positioning belt applied. NA #4 indicated that although it would have been her responsibility to apply the belt for Resident #39, she had forgotten to apply it after transferring the resident into the wheelchair. NA #4 further identified that Resident #39 was supposed to wear the belt because the resident tended to slide forward when in the wheelchair. Subsequent to surveyor inquiry, NA #4 applied the pelvic positioning belt for Resident #39. Observation and interview with LPN #1 on 3/19/25 11:11 AM identified that Resident #39's assigned NA would have been responsible to apply and maintain application of the belt for the resident while seated in the wheelchair. LPN #1 indicated the NA would know to apply the pelvic positioning belt by referencing her NA assignment information in the resident's Electronic Medical Record (EMR). Interview and review of the clinical record with the Director of Nursing Services (DNS) on 3/19/25 at 1:17 PM identified Resident #39 had a pelvic positioning belt ordered as the resident tended to slide out of the wheelchair. The DNS indicated the belt should have been applied by the nursing staff and the NA must have forgotten to apply it. The DNS identified he would speak with the nursing supervisor about the application of Resident #39's positioning belt. Observation and Interview with LPN #6 on 3/20/25 at 2:20 PM identified Resident #39 was leaning forward in the wheelchair while self-propelling past the nurse's station using his/her bilateral lower extremities. Resident #39 was observed doing so without the benefit of having his/her pelvic positioning belt applied. LPN #6 indicated Resident #39 needed to have the belt applied but the NA must have forgotten to apply the positioning belt. Subsequent to surveyor inquiry, LPN #6 applied the pelvic positioning belt for Resident #39. Interview and review of the clinical record with PT #1 on 3/24/25 at 10:18AM identified Resident #39 had the pelvic positioning belt ordered to help keep proper position when seated in the wheelchair. PT #1 indicated that OT #1 conducted an in-service on 3/12/25 with the nursing staff on the application and usage of the belt. Review of the clinical record with PT #1 reflected a physician's order was put in place for the pelvic positioning belt on 3/17/25. PT #1 identified that if the pelvic positioning belt was not applied for Resident #39 then his/her positioning in the wheelchair would not be optimal and the resident would be at higher risk for falls. PT #1 further indicated that nursing staff would have been responsible to apply and maintain the application of the pelvic positioning belt for Resident #39 when the resident was seated in the wheelchair. Review of the facility policy, Physician's Orders, dated 7/23, directed orders must be documented and entered into the clinical record by the licensed nurse with the purpose to provide residents with prompt and accurate treatment. Review of the facility policy, Nursing Policy and Procedures, dated 7/23, directed physical therapy is provided in accordance with the resident's needs and shall be prescribed by the physician to ensure all resident's rehabilitative services are met. Although requested, a policy on wheelchair equipment/pelvic positioning belts was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 sampled residents (Resident #57) reviewed for accidents and hazards, the facility failed to provide an assistive device and supervision with ambulation per the physician's order for a resident who was a high fall risk and for 1 of 3 sampled residents (Resident #84) reviewed for dementia care, the facility failed to provide supervision with ambulation at mealtime per the physician's order for a resident with dementia and dysphagia. The findings include: 1. Resident #57's diagnoses included dementia, muscle weakness, unsteadiness on his/her feet and a history of falling. A Morse fall scale evaluation dated 2/7/25 identified Resident #57 used an ambulatory aide (walker) and was a high risk for falling. A Physical Therapy (PT) evaluation and plan of treatment dated 2/7/25 identified Resident #57 was a fall risk and required supervision with a 2 wheeled walker as an assistive device. An Occupational Therapy (OT) evaluation and plan of treatment dated 2/7/25 identified Resident #57 had a history of falls, had moderately impaired safety awareness, and an impairment of balance and strength. A physician's order dated 2/11/25 directed transfers and ambulation with supervision and the use of a 2 wheeled walker in Resident #57's room and hallways. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 was severely cognitively impaired and required supervision or touch assistance for transfers, toileting, and bed mobility. The MDS indicated the use of a mobility device/walker. The Resident Care Plan dated 3/2/25 identified Resident #57 had limited physical mobility, a self-care performance deficit, and a risk for falls. Interventions included ambulation and transfers with supervision and a 2 wheeled walker in his/her room and hallways, provide supportive care and assistance with mobility as needed and assistance of 1 for bathing, dressing, and toileting. Observation on 3/17/25 at 12:30 PM identified Resident #57 was ambulating to the recreation room for lunch without the benefit of staff supervision or a 2 wheeled walker. Observation and interview with NA #1 on 3/18/25 at 10:53 AM identified Resident #57 was an assist of 1 for ambulation and did not have or use an assistive device for ambulation. NA #1 was unable to locate a 2 wheeled walker in Resident #57's room and indicated she had not observed the resident ambulate with an assistive device ever before. NA #1 identified she was not aware Resident #57 needed a 2 wheeled walker, and she would need to ask the charge nurse about the wheeled walker use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and review of the clinical record with LPN #6 and NA #9 on 3/20/25 at 2:20 PM identified Resident #57 was ambulating from his/her room to the nurse's station without the benefit of staff supervision and a 2 wheeled walker. LPN #6 and NA #9 indicated they were not aware Resident #57 was supposed to be supervised and use an assistive device when ambulating. LPN #6 went to Resident #57's room where a 2 wheeled walker was found folded and leaning against the wall. LPN #6 brought the walker to Resident #57 where he/she was seated in front of the nurse's station and instructed the resident on its use. Review of the clinical record with LPN # 6 and NA #9 indicated that Resident #57 had a current order for supervision and a 2 wheeled walker when ambulating in his/her room and hallways. LPN #6 identified that ambulation orders were determined by recommendations from the Physical Therapist (PT) and that she would follow-up with them regarding Resident #57's status. Subsequent to surveyor inquiry, on 3/21/25 a physician's order indicating supervision with ambulation in his/her room and hallways was in the clinical record for Resident #57 (the 2 wheeled walker was removed). Interview and review of the clinical record with PT #1 on 3/24/25 at 10:18 AM identified that Resident #57 had a 2 wheeled walker ordered which should have been utilized with staff supervision while the resident was ambulating. PT #1 indicated that it would have been her department that would have provided Resident #57 with a 2 wheeled walker when it was first ordered, and she was unsure why the walker was not provided. PT #1 identified that although Resident #57 was re-evaluated and determined to not need the 2 wheeled walker on 3/21/25, Resident #57 continued to need staff supervision because the resident was a high fall risk. Review of the facility policy, Ambulation with a Walker, dated 6/23, directed that assistance with the use of a walker during ambulation will be provided to residents by nursing or rehab as indicated by a physician's order. 2. Resident #84's diagnoses included dementia, dysphagia, and muscle weakness. The admission Minimum Data Set assessment dated [DATE] identified Resident #84 was severely cognitively impaired and required partial to moderate assistance with bed mobility, toileting, and transfers. Coughing or choking during meals or when swallowing medications and complaints of difficulty or pain when swallowing. a. The Resident Care Plan (RCP) dated 2/13/25 identified Resident #84 had a self-care performance deficit, limited physical mobility, and was at risk for falls with a history of falls. Interventions included 1:1 assistance for meals, transfers and ambulation assistance of 1 (hand-held assistance). A Morse fall scale evaluation dated 1/14/25 identified Resident #84 was a moderate risk for falling. A physician's order dated 2/20/25 directed transfers and ambulation with assistance of 1 via hand-held assistance in room and hall for Resident #84. Observation on 3/18/25 at 2:00 PM identified Resident #84 was ambulating without the benefit of staff supervision or assistance in the [NAME] hallway towards the nurse's station. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, interview, and review of the clinical record with LPN #1 on 3/19/25 at 10:54 AM identified Resident #84 was ambulating without the benefit of staff assistance in the [NAME] hallway towards the nurse's station where LPN #1 was standing. LPN #1 indicated that although Resident #84 was an assist of 1 and a hand-held assist for ambulation per his/her current physician's orders, she was too busy to watch him/her and hold his/her hand all day. LPN #1 further identified that she would notify the provider that Resident #84 needed another physical therapy (PT) evaluation. Subsequent to surveyor inquiry, an interview with LPN #1 on 3/19/25 at 11:00 AM identified she had spoken to the provider and a new PT evaluation was being initiated for Resident #84. Interview and review of the clinical record with the Director of Nursing Services (DNS) on 3/19/25 at 1:17 PM identified Resident #84 was an assist of 1 and hand-held assist with ambulation in his/her room and hallway per the current physician's orders. The DNS indicated that although nursing staff have tried to keep Resident #84 in common areas of the unit for closer monitoring, the root cause of the resident's fall earlier in his room was a lack of staff supervision. The DNS further identified Resident #84 should not have been ambulating in his room or hallway without staff supervision/hand-held assistance and that he needed to speak with the nursing staff further. Interview and review of the clinical record with PT #1 on 3/24/25 at 10:18 AM identified per her recommendations and the current physician's order, Resident #84 was an assist of 1/hand-held assist in his/her room and hallway when ambulating. PT #1 indicated that if Resident #84 was allowed to ambulate independently he/she was a high risk for falls due to unsteadiness and a recent decline in function. PT #1 further stated that although the nursing staff was provided education after Resident #84's last PT eval, the staff should have continued to review the resident's orders, progress notes, and ambulation status to provide the appropriate level of supervision and assistance. PT #1 indicated that she would need to provide further education to the nursing staff regarding Resident #84. Review of the facility Ambulation policy, dated 6/23, directed staff are to assist residents to ambulate as per the physician order or plan of care. b. The RCP dated 2/13/25 indicated Resident #84 had a swallowing problem related to a diagnosis of dysphagia. Interventions included instructing resident to eat slowly and monitor for signs of aspiration or choking during meals. A physician's order dated 2/20/25 directed Resident #84 was a 1:1 assist for meals. Review of the North/West unit mealtime guidelines, updated 3/17/25, identified Resident #84 required supervision with meals. Observation on 3/19/25 at 9:16 AM identified NA #6 entered Resident #84's room with a breakfast tray, exited the room without the tray, and closed the door to the resident's room. LPN #1 was notified and entered Resident #84's room. LPN #1 indicated she found the resident in the room with his/her breakfast and needed to get a NA to assist Resident #84 with his/her meal. LPN #1 proceeded to leave Resident #84's room, without the meal tray, and closed the door. Observation at 3/19/25 at 9:18 AM identified a loud noise was heard from Resident #84's room and LPN #1 opened the door to Resident #84's room and found the resident seated on the floor with the bedside table tipped over and breakfast items spilled on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 3/19/25 at 9:58 AM identified Resident #84 had an unwitnessed fall in his/her room and was observed sitting on the floor in front of his/her bedside table. Resident #84 stated he/she was eating breakfast. The nurse's note indicated after the fall Resident #84 was assisted to a common area of the unit. Interview and review of the clinical record with LPN #1 on 3/19/25 at 10:35 AM identified Resident #84 was a 1:1 assist with meals and NA #6 should not have left the resident alone with his/her meal. LPN #1 indicated NA #6 was responsible to know what supervision and assistance level was necessary for Resident #84 to eat, and if unsure, should have asked her. LPN #1 identified she would need to review NA #6's assignment with her again. Interview with NA #6 on 3/19/25 at 10:40 AM identified she brought Resident #84 his breakfast tray, put it on the tray table in front of the resident and left the room. NA #6 indicated that although she exited Resident #84's room to serve other breakfast trays on another hallway, she did not let anyone know that she had served Resident #84 his breakfast and left the resident alone in his/her room. NA #6 further stated Resident #84 did not need help with his/her meals and was able to eat by him/herself. When asked to access the Kardex/care card for Resident #84, NA #6 was unable to locate the resident's care specific information on her tablet and proceeded to ask LPN #1 for assistance. Interview and review of the clinical record on 3/19/25 at 10:50 AM with LPN #1 and NA #6 identified Resident #84's Kardex/care card indicated the resident was a 1:1 assist with meals and review of the resident's care plan directed the resident required supervision with meals. NA #6 indicated she should have known Resident #84's care specific information before serving the breakfast tray to the resident. Interview and review of the clinical record with the DNS on 3/19/25 at 1:17 PM identified Resident #84 was a 1:1 assist at mealtime and the resident needed set up, cueing and supervision during meals. The DNS indicated Resident #84 should not have been served his breakfast tray and then left alone in his/her room. The DNS identified the NA or LPN should have stayed with Resident #84, or the resident should have been served the meal in a common area. Additionally, the DNS was unable to indicate why NA #6 could not access Resident #84's care specific information and stated he would need to speak to NA #6 and provide her further training. Interview and review of the clinical record with OT #1 on 3/24/25 at 10:25 AM identified Resident #84 was a 1:1 assist and needed staff supervision with meals. OT #1 indicated that Resident #84 should have all meals in the dining room but if dining in his/her room then he/she was to be supervised and assisted by staff. OT #1 further identified Resident #84 required help and encouragement to eat and had a potential for choking due to a swallowing difficulty (dysphagia). OT #1 indicated that although she had just recently updated the mealtime guidelines for the nursing staff on this unit, she was unable to indicate why Resident #84 was not supervised and assisted while eating and stated she would need to provide further education to the nursing staff. Although requested, a policy on dining guidelines/meal supervision was not provided. 50249 Surveyor: Otwoma, [NAME] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50250

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on interviews, record review, and facility policy for 1 of 3 sampled residents (Resident #96) reviewed for pressure ulcers, the facility failed to provide adequate hydration to a resident with a potential for a fluid deficit. The findings included: Resident #96's diagnoses included pressure ulcer of the sacral region, neuromuscular dysfunction of the bladder, and congestive heart failure (CHF). A Dietary Nutritional Admission assessment dated [DATE] identified Resident #96's fluid intake goal was 1400-1700 ml per 24 hours. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #96 was cognitively intact, required set up for eating/drinking, and was dependent on staff for hygiene. Additionally, the MDS identified Resident #96 was on a diuretic (a medication that promotes fluid loss through urination). The Resident Care Plan dated 2/13/25 identified Resident #96 had a potential for a fluid deficit related to congestive heart failure, diuretic therapy, and bilateral lower extremity edema. Interventions included educating the resident/family/caregivers on the importance of fluid intake, monitoring and documenting intake and output per facility policy, and monitoring/documenting/reporting any signs and symptoms of dehydration as needed. A record review of Resident #96's intake for 3/1/25 through 3/19/25 failed to identify that the resident met his/her estimated fluid goals for any of the 19 days reviewed. (24-hour intake ranged from 240cc to 1200cc). A registered dietician note dated 3/12/25 at 11:25 AM identified a follow up visit secondary to the resident's appetite and intake, Resident #96 reported a decline in appetite and intake at the time, and education was provided on the importance of adequacy of intake. A physician's order dated 3/13/25 directed for Resident #96 to have a fluid intake goal of 1400-1700 ml every 24 hours. Additionally, the nurse was directed to document Resident #96's intake and output every shift and the 3:00 PM to 11:00 PM shift nurse was to total the entire 24-hour intake and output. APRN #1's progress note on 3/18/25 identified increased confusion and urinary retention, with foley placement and an order for Resident #96 to start on antibiotics, a follow up visit on 3/19/25 identified Bumex (diuretic) was discontinued and that Resident #96 continued to be able to push fluids by mouth. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of nurses notes from 3/1/25 to 3/24/25 identified on 3/17/25 at 6:22 AM Resident #96 was alert and forgetful, not voiding, denied pain or discomfort and hematuria (blood in the urine) during urination, He/she had 240 ml fluid intake, and an attempt at foley placement was unsuccessful with Resident #96 voiding 25cc in the process. Fluids were encouraged. Additionally, on 3/17/25, Resident #96 was seen by APRN #1 due to not voiding, a urinalysis and laboratory work was ordered, the resident was alert and confused, tolerated fluids well, and a foley was inserted for urine retention with an output of 200cc that shift. On 3/18/25 at 6:44 AM the resident was alert and confused, with light amber urine draining via urinary catheter, at 2:28 PM identified Resident #96 was started on Ciprofloxacin (an antibiotic), for a Urinary Tract Infection (UTI). On 3/19/25 at 11:31 PM Resident #96 was alert and oriented with increasing confusion at baseline, but overall confusion was worse on the shift and on 3/24/25 at 2:49 PM it was identified that Resident #96 was confused, tolerated fluids well with dark yellow urine draining via urinary catheter. Review of Resident #96's BUN/Creatinine laboratory results (indicative of kidney function and potential dehydration) identified the following laboratory results: on 3/17/25 BUN/Creatinine was 39/2.2, 3/20/25 was 34/1.7, 3/24/25 was 35/2.1 and 3/27/25 was 40/2.0. The BUN/Creatinine laboratory results for Resident #96 from 3/13/25 were normal at 21/1.3. (The normal reference range for BUN is 10-24, and creatinine is 0.7 to 1. 5, indicating potential dehydration.) APRN #1's progress note on 3/24/25 identified increased confusion with light yellow urine, with the plan of care to continue pushing fluids by mouth and to start a voiding trial so that the urinary catheter could be discontinued. A record review failed to identify a Dehydration Assessment was completed from 3/1/25 through 3/19/25, with the most current Dehydration Assessment being completed on 1/14/25. An interview with Licensed Practical Nurse #2 on 3/18/25 at 2:46 PM identified the Nursing Assistants were responsible for documenting intake and output into a book at the nurses' station, then the nurse on each shift entered the information into the electronic health record. Additionally, the 3:00 PM to 11:00 PM nurse was responsible to calculate the 24 hour total and notify the Registered Nurse (RN) Supervisor if there was an issue with the resident's intake. Interview with RN Supervisor #1 on 3/19/25 at 1:28 PM identified Resident #96 did not void on the 3/17/25 night shift, and per a verbal report from that RN and Resident #96's history of urinary retention APRN #1 was notified and gave orders to insert a urinary catheter. Additionally, RN #1 identified the 3:00 PM to 11:00 PM shift was responsible for calculating the 24 hour intakes. If the intake was insufficient, the facility notified the provider and pushed fluids. RN #1 indicated that this had occurred for Resident #96. Interview and intake and output review with APRN #1 on 3/19/25 at 3:06 PM identified she gave orders for a urinary catheter because it was reported that Resident #96 did not void on the 3/17/25 night shift. She failed to identify that she reviewed Resident #96's intake and output and stated she does not go by that, just the information that is given to her, which was Resident #96 had not voided all shift with a 25cc output when the nurse attempted to insert a urinary catheter. APRN #1 could not identify if she would expect Resident #96 to have sufficient output considering the intake that did not meet Resident #96's fluid goals or if the low output was due to dehydration. She stated that she ordered laboratory work, with follow up labs ordered for 3/18/25 and that Resident # 96's Bumex (diuretic) was held. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the Dietician on 3/20/25 at 2:06 PM identified she evaluated residents quarterly, weekly, and as needed and she calculated estimated fluid intake needs during the initial Nutritional Assessment. Resident #96's fluid needs were calculated by weight, Body Mass Index (BMI) and diagnosis of CHF, and were estimated to be 1400-1700 cc in a 24-hour period. She added that especially for a resident with CHF fluid intake needs to be realistic, and not over 1800 cc in a 24 hour period, additionally if a resident was consistently not meeting their fluid goals she would expect them to be assessed for dehydration, and lab work to be performed. Review of the Dehydration policy dated 7/12 directed that it is the facility policy to ensure residents are meeting their estimated fluid needs and/or identify resident at risk for dehydration. Additionally, the policy outlined that the dietician will recommend an estimated fluid goal, and if a resident has consumed less than their estimated fluid goal for 3 consecutive days the resident would be evaluated for signs and symptoms of dehydration. 51102

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #50) reviewed for respiratory care, the facility failed to ensure a physician's order was in place when administering continuous oxygen. The findings include: Resident #50's diagnoses included pneumonitis, Congestive Heart Failure (CHF), pleural effusion, and resolved bronchitis and hypoxia (low oxygen). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #50 was severely cognitively impaired and was dependent with bed mobility, toileting, and transfers. The Resident Care Plan dated 1/5/25 identified altered cardiovascular status and anemia. Interventions included monitoring for shortness of breath and deterioration of respiratory status, monitor vital signs, and administer medications as ordered. Review of Resident #50's March 2025 Treatment Administration Record (TAR) identified a physician's order, beginning on 2/24/25 for Oxygen 0 to 4 liters per minute (lpm) to maintain an oxygen saturation greater than 92%. The end date of the order was noted as 3/10/25. The March 2025 TAR failed to reflect a physician's order directing oxygen was to be in place from 3/11/25 until 3/18/25. A nurse's note dated 3/12/25 at 10:19 PM identified Resident #50 was receiving oxygen at 2 lpm via nasal cannula with an oxygen saturation of 97%. A Nurse Practitioner (NP) progress note dated 3/14/25 at 5:41 PM identified Resident #50 had a chest x-ray which showed pneumonitis and improved CHF. The progress note indicated Resident #50 had an oxygen saturation of 97% on oxygen at 2 liters and mild shortness of breath. A nurse's note dated 3/15/25 at 11:30 PM identified Resident #50 was receiving oxygen at 2 lpm via nasal cannula with an oxygen saturation of 96%. An observation on 3/17/25 at 10:00 AM identified Resident #50 was in bed with his/her eyes closed with continuous oxygen at 2 lpm via nasal cannula in place. An observation on 3/17/25 at 11:00 AM identified Resident #50 was seated in his/her wheelchair in the recreation room with portable continuous oxygen in place at 2 lpm via nasal cannula. An observation and interview with LPN #3 on 3/18/24 at 10:11AM identified Resident #50 was seated in his/her wheelchair in the recreation room without oxygen in place. LPN #3 obtained an oxygen saturation on room air for Resident #50 and received a reading of 86%. LPN #3 identified that although Resident #50 has been on continuous oxygen recently, she was unsure why he/she was not on it now. LPN #3 placed Resident #50 on portable continuous oxygen at 2 lpm via nasal cannula and obtained an updated oxygen saturation reading of 95%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and review of the clinical record with LPN #4 on 3/18/25 at 10:21 AM identified that Resident #50 did not have a current physician's order for oxygen in his/her clinical record. LPN #4 identified Resident #50 was recently put on continuous oxygen and she was unsure why there was not a current physician's order in place. LPN #4 identified it would have been the responsibility of the charge nurse or nursing supervisor to ensure there was a current order for Resident #50 to receive continuous oxygen and that she would call the provider to get an order. Interview and review of the clinical record with the RN supervisor (RN #1) 3/18/25 at 10:28 AM identified that although oxygen was being continuously administered to Resident #50, the resident did not have a current physician's order in his/her clinical record. RN #1 indicated that continuous oxygen should not have been administered to Resident #50 without a physician's order and that it would have been up to her or the charge nurse to obtain an order from the provider. RN #1 identified she was not sure why a new oxygen order was not obtained for Resident #50 following the 3/10/25 end of oxygen administration treatment, and that she would call the provider for a new order. Subsequent to surveyor inquiry, on 3/18/25 at 10:45 AM a physician's order for Oxygen 0 to 4 liters to keep oxygen saturation greater than 92% was obtained from the provider for Resident #50. An NP progress note dated 3/18/25 at 3:37 PM identified Resident #50 was found to have an oxygen saturation in the high 70% range on room air and he/she was placed on 4 lpm of oxygen with an improved oxygen saturation of 99%. On exam, Resident #50 was tachypneic (elevated respiratory rate) with an elevated heart rate in the 110's while seated in the wheelchair in the common room and he/she was also found to be grunting and short of breath. The NP progress note indicated Resident #50 would be treated for atypical pneumonia and to administer oxygen to keep the resident's oxygen saturation greater than 92%. Interview and review of the clinical record with the DNS on 3/19/25 at 1:17 PM identified oxygen administration required a physician's order, and that Resident #50 had needed and received continuous oxygen for several weeks. The DNS indicated that the RN supervisor would have been responsible to contact the provider to obtain an order for oxygen administration for Resident #50. The DNS further identified that the resident's oxygen order had not been renewed after 3/10/25 due to poor follow through. Review of the facility policy, Oxygen Administration, undated, directed that a physician's order is required for continuous administration of oxygen. The policy further directed that when oxygen therapy is ordered the licensed clinician would verify the physician's order.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility policy, and interviews for the only sampled resident, (Resident #66), reviewed for hemolytic treatment, the facility failed to ensure appropriate communication occurred between the hemolytic treatment center and the facility. The findings include: Resident #66's diagnoses included end stage renal disease, dependence on hemolytic treatment, and anemia. A physician's order dated 1/19/25 directed to send Resident #66 to hemolytic treatments 3 times per week. On the resident's return, staff were to record the resident's hemolytic center weight from the communication book to ensure consistency. The admission Minimum Data Set assessment dated [DATE] identified Resident #66 was cognitively intact and required partial moderate assistance with personal hygiene, dressing, bed mobility, transfer, and toileting, and required set up assistance with eating. Additionally, Resident #66 was receiving hemolytic treatment. A. The Resident Care Plan dated 1/25/25 identified, for consistency, the facility was to record weights from the hemolytic communication book, encourage Resident #66 to go for the scheduled hemolytic treatment appointments, weigh the resident as ordered, and notify the physician of any significant weight changes. Review of the hemolytic treatment center's communication book and clinical record documentation of visits from 1/27/25 through 3/19/25 identified that on 2/19/25, 2/24/25, 2/28/25, and 3/5/25 hemolytic treatment center documentation was missing. Review of the nurse's notes failed to indicate facility staff contacted the hemolytic treatment center for a treatment report. Interview and observation with LPN #5 on 3/19/25 at 10:38 AM identified that although Resident #66 went for treatment, the treatment book used for communication between the center and facility lacked paperwork from the 3/17/25 visit. LPN #5 indicated that the hemolytic treatment communication book was sent with Resident #66 but sometimes Resident #66 did not return with paperwork. Further, the communication book came back to the floor nurse and the supervisor received the paperwork. An interview with RN Supervisor #1 on 3/19/25 at 12:22 PM identified that she did not have any paperwork from the hemolytic treatment center for the 3/17/25 visit, but she would call and request they send over the information. Subsequent to surveyor inquiry, the center was called, documentation of vital signs and a post treatment weight was faxed to the facility. A nurse's note dated 3/19/25 at 1:14 PM identified Resident #66 went for hemolytic treatment at 10:15 AM, and that the hemolytic treatment communication book was sent. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 3/19/25 at 4:49 PM identified Resident #66 returned from hemolytic treatment without a progress note in the hemolytic treatment binder. Review of the treatment center binder identified a blank documentation form with a date of 3/19/25. A nurse's note dated 3/20/25 at 7:44 AM identified the Assistant Director of Nursing spoke to a nurse at the hemolytic treatment center, requested a note from the 3/19/25 visit, the documentation was received, and the information included a post treatment vital signs and weight. Review of Resident #66's clinical information identified that for 6 out of 25 opportunities, the facility failed to ensure communication documentation was received from the hemolytic treatment center. Further, for 6 out of 25 opportunities, Resident #66's weight was missing, therefore the facility was unable to follow the physician order dated 1/20/25 to record post treatment weights. Interview with RN #6 (hemolytic treatment center nurse) on 3/20/25 at 1:54 PM identified that on 3/17/25 and 3/19/25, Resident #66 arrived without his/her hemolytic treatment communication book. Interview on 3/20/25 at 3:30 PM with Director of Nursing and Administrator identified that Resident #66's communication binder was supposed to be sent with Resident #66 to hemolytic treatment. The binder included Resident #66's list of medications, a transfer sheet, and a consult sheet. If the binder did not contain documentation from the hemolytic treatment center upon the residents return, the facility practice was to call the hemolytic treatment center to obtain the information. The DNS was unable to explain why the information had not been requested from Resident #66's visits on 3/17/25 and 3/19/25, but that he would ensure the facility called to receive missing information. Additionally, he could not explain any of the missing forms. Review of the nursing home hemolytic treatment agreement, in part, identified the facility will provide for the interchange of information useful or necessary for the care of the designated resident and will inform the center of a contact person at the facility whose responsibilities include oversight of provision of hemolytic treatment services by the center to the designated resident of the facility. Although requested, a facility specific policy for hemolytic treatment communication and documentation was not provided. B. A physician's order dated 1/20/25 directed nursing staff, every shift, to document intake and output, and that the 3:00 PM to 11:00 PM shift was to total and document the entire fluid intake over a 24 hour period. A Resident Care plan dated 1/22/25 identified Resident #66 was assessed with moderate malnutrition, on hemolytic treatment, weight fluctuations, and on a fluid restriction. Interventions included providing a diet as ordered, double portions, fluid restriction, and supplements as ordered. A Physician's order dated 1/22/25 directed a fluid restriction of 1200 cubic centimeters (cc) in 24 hours. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The updated Resident Care Plan dated 1/25/25 identified that Resident #66's had a Fluid Restriction (FR) of 1200cc per 24-hour period. A review of the Medication Administration Record (MAR) dated 2/1/25 through 3/19/25 identified that although fluid amounts for each shift were entered, the facility failed to ensure the total amounts of fluid taken in by Resident #66 for each 24 hour period were totaled on the 3:00 PM to 11:00 PM shift and per the physician order. This occurred for the entire time period reviewed (47 days). When fluid amounts were totaled by the surveyor the following 24 hour amounts were noted to exceed the 1200 cc fluid restriction: On 2/1/25 the 24 hour intake was 1320 cc (120 cc over the 1200 cc FR), on 2/6/25 the 24 hour intake was 1360 cc (over 160 cc), on 2/11/25 the 24 hour intake was 1300cc (over 100 cc), on 2/12/25 the 24 hour intake was 1320 cc (120 cc over), on 2/13/25 the 24 hour intake was 1680 cc (480 cc over), on 2/14/25 the 24 hour intake was 1240 cc (40 cc over), on 2/22/25 the 24 hour intake was 1380 cc (180cc over), on 2/23/25 the 24 hour intake was 1380 cc (180 cc over), on 2/24/25 the 24 hour intake was 1400 cc (200 cc over), on 3/4/25 the 24 hour intake was 1620 cc (420 cc over), on 3/5/25 the 24 hour intake was 1500 cc (300 cc over), on 3/6/25 the 24 hour intake 1320 cc (120 cc over), on 3/8/25 the 24 hour intake was 1440 c (240 cc over), on 3/15/25 the 24 hour intake was 1320 cc (120 cc over), and on 3/17/25 the 24 hour intake was 2550 cc (1350 cc over). Out of 47 days, Resident #66 exceeded his/her fluid restriction of 1200 cc 15 times. An interview with Registered Nurse (RN) Supervisor #1 on 3/19/25 at 12:22 PM identified she was unaware Resident #66 had exceeded the 1200 cc fluid restriction 15 times. RN #1 stated that Resident #66 was non-compliant with maintaining his/her fluid restriction, but it was not her responsibility to monitor Resident #66's fluid intake. RN #1 further stated it was the responsibility of the dietician or the Assistant Director of Nursing (ADNS) to oversee Resident #66's intake and that the 3:00 PM to 11:00 PM shift nursing staff were responsible for totaling the 24-hour intake amounts. Interview with the Assistant Director of Nursing Services (ADNS) on 3/19/25 at 12:29 PM identified she was unaware that Resident #66 had exceeded his/her fluid restriction of 1200 cc. Additionally, although she was to receive the 24 hour totals, she was unable to explain why she did not know Resident #66 exceeded his/her fluid restriction or why no one was notified of the overage. Interview on 3/20/25 at 3:24 PM with the Dietician identified that she follows Resident #66's fluid restriction and weights with the hemolytic treatment center dietician. Interview with RN Supervisor #2 on 3/20/25 at 5:05 PM identified that although she thought the 3:00 PM to 11:00 PM shift was responsible for totaling the 24-hour intake, it may have been the 11:00 PM to 7:00 AM shift's responsibility. She was unsure if the 11:00 PM to 7:00 AM supervisor was notified of the 24-hour totals and further stated that she thought that the ADNS reviewed the 24-hour totals. Interview with the Director of Nursing (DNS) and Administrator on 3/20/25 at 3:30 PM identified that the facility policy indicates the 3:00 PM to 11:00 PM shift was responsible for totaling the daily 24 hour intake amounts. Once the 24 hour amounts were totaled, the information went to the ADNS. The DNS was unable to explain why the facility had not totaled the 24 hour intakes and had not identified when Resident #66 exceeded his/her fluid limit. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the intake and output policy dated 6/23 directed to provide an accurate record of the resident's intake and output. Intake and output will be monitored by the resident's hydration status, risk for dehydration, and/ or physician's order. Intake and output are documented on each shift beginning with the 11:00 PM to 7:00 AM shift. Intake and output are totaled daily by the 3:00 PM to 11:00 PM nurse.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations and interviews for 2 of 6 sampled residents reviewed for accidents (Resident #57 and Resident #84), the facility failed to ensure staff competency related to electronic medical record (EMR) use. The findings include: 1. Resident #57's diagnoses included dementia, muscle weakness, unsteadiness on feet and a history of falling. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 was severely cognitively impaired and required supervision or touch assistance for transfers, toileting, and bed mobility. The MDS indicated use of a mobility device/walker. The Resident Care Plan dated 3/2/25 identified Resident #57 had limited physical mobility, a self-care performance deficit, and a risk for falls. Interventions included ambulation and transfers with supervision and a 2 wheeled walker in the room and hallways, provide supportive care and assistance with mobility as needed, and assistance of 1 for bathing, dressing, and toileting. An interview, observation, and review of the clinical record on 3/20/25 at 2:20 PM with LPN #6 and NA #9 identified NA #9 was unable to access the EMR when requested to determine the current ambulation status and level of supervision for Resident #57. NA #9 indicated she did not know how to access the requested information via the facility tablet or laptop devices and needed to ask LPN #6 to obtain the information. LPN #6 was able to access Resident #57's information on the computer at the nurse's station and proceeded to instruct NA #9 how to do so herself. LPN #6 identified NA #6 should have been able to retrieve Resident #57's information in the EMR when asked and indicated she would let the DNS know. Interview with the Registered Nurse Supervisor (RN #5) on 3/24/25 at 10:42AM identified that NA #9 should have been able to access Resident #57's care specific information on the care card and Kardex in the EMR. RN #5 was unable to indicate why NA #9 was unable to operate the device or access Resident #57's EMR information when requested. RN #5 indicated that the facility's nursing staff had been trained on technology and NA #9 should have had the knowledge and competencies to access the resident's EMR information to provide individualized care to the resident. RN #5 further identified that she would make the DNS aware so additional training could be provided. 2. Resident #84's diagnoses included dementia, dysphagia, and muscle weakness. The admission Minimum Data Set assessment dated [DATE] identified Resident #84 was severely cognitively impaired and required partial to moderate assistance with bed mobility, toileting, and transfers. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan (RCP) dated 2/13/25 identified Resident #84 had a self-care performance deficit, limited physical mobility, and was at risk for falls with a history of falls. Interventions included 1 to 1 assistance for meals with transfers and ambulation assistance of 1 (hand-held assistance). The RCP further indicated Resident #84 had a swallowing problem related to a diagnosis of dysphagia. Interventions included instructing Resident #84 to eat slowly and monitor for signs of aspiration or choking during meals. An interview, observation, and review of the clinical record on 3/19/25 at 10:40 AM with LPN #1 and NA #6 identified NA #6 was unable to access the EMR when requested to determine the current ambulation status and level of supervision for Resident #84. NA #6 indicated she did not know how to access the requested information via the facility tablet device and was unable to recall Resident #84's mealtime guidelines and needed to ask LPN #1 to obtain the information. LPN #1 was able to access Resident #84's information on the computer on the medication cart and proceeded to instruct NA #6 how to do so herself. LPN #1 identified NA #6 should have been able to retrieve Resident #84's information in the EMR when asked to and indicated the NA needed to receive additional training. Interview with the Registered Nurse Supervisor (RN #5) on 3/24/25 at 10:42 AM identified that NA #6 should have been able to access Resident #84's care specific information on the care card and Kardex in the EMR. RN #5 was unable to indicate why NA #6 was unable to operate a device or access Resident #84's EMR information when requested. RN #5 indicated that the facility's nursing staff had been trained on the technology and NA #6 should have had the knowledge and competencies to access the resident's EMR information to provide individualized care to the residents. RN #5 further identified that she would make the DNS aware so additional training could be provided. Interview with the DNS on 3/24/25 at 10:51AM identified that NA #6 and NA #9 should have been able to access Resident #57 and # 84's care specific information on the care card or Kardex tab in the EMR. The DNS indicated that the facility's nursing staff was trained to access the resident specific care information via tablet, laptop or the touch screen wall monitors (located within the units of the facility). The DNS identified that NA #6 and #9 were provided education and a 4-hour class, which was mandatory, when the facility transitioned to a new EMR system in June 2024. The DNS indicated he would expect to be notified by the charge nurse or nursing supervisor if a NA was unable to operate a device or access the EMR system and if it had been brought to his attention, he would have provided direct education to ensure NA #6 and NA #9 possessed the necessary skill sets to provide safe care. The DNS further identified he needed to schedule another EMR training for the NA staff at the facility. Although requested a policy on EMR training for nursing staff was not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #66) reviewed for hemolytic treatments, the facility failed to provide appropriate packaging for medication being sent with a resident for hemolytic treatments and failed to assess a resident for self-administration of medication. Additionally, the facility failed to ensure narcotic keys for the medication cart were safely kept with the charge nurse, failed to ensure bimonthly narcotic audits were conducted, and failed to ensure narcotics for destruction in the Director of Nursing (DNS) office were stored appropriately. The findings include: 1. Resident #66's diagnoses included end stage renal disease, dependence on hemolytic treatment and anemia. A Physician's order dated 1/17/25 directed to send hydralazine (lowers blood pressure) 100 milligrams 1 tablet on Monday, Wednesday and Friday with Resident #66 to his/her hemolytic treatments. A physician's order dated 1/19/25 directed hemolytic treatment 3 times a week. The admission Minimum Data Set assessment dated [DATE] identified Resident #66 was cognitively intact and required partial moderate assistance with personal hygiene, dressing, bed mobility, transfer, and toileting, and required set up assistance with eating. Additionally, Resident #66 was receiving hemolytic treatment. The Resident Care Plan dated 1/25/25 identified hemolytic treatment related to renal failure. Interventions included administering medications as ordered, hemolytic treatment 3 times a week on Monday, Wednesday and Friday and encourage the resident to go for the scheduled treatment appointments. A nurse's note dated 3/4/25 at 4:44 AM identified Resident #66 was on leave of absence at 3:45 PM via wheelchair and returned via wheelchair at approximately 8:00 PM. Resident #66 did not return with the hemolytic treatment binder. A call was placed to the hemolytic treatment center, but the hemolytic treatment center had closed. All medications were given with the exception of the 9:00 PM Hydralazine. Resident #66 could not confirm if this medication was taken at hemolytic treatment provider, stating I took some pills there, I don't know what. Observation on 3/19/25 at 8:24 AM of the hemolytic communication binder identified a clear plastic pouch with a single orange pill; handwritten in black marker read hydralazine 100 mg, Resident #66's name, and 2 staples were noted to close the pouch. The clear pouch was tucked into the binder's plastic sleeve containing a consultation document. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #5 on 3/19/25 at 10:38 AM identified that the hemolytic communication book and medication were sent with Resident #66. LPN # 5 further identified that she removed the medication from Resident #66's blister card of medication, placed it into the plastic pouch, labeled it and sent the medication in the hemolytic treatment communication binder with Resident #66. The medication to be sent with Resident #66 failed to be packaged from the pharmacy. LPN #5 was unable to identify how the nurse at the center would confirm that the medication in the plastic pouch in the binder was hydralazine. A nurse's note dated 3/19/25 at 1:14 PM identified Resident #66 went to his/her hemolytic treatment at 10:15 AM, and the hemolytic treatment book and medication were sent with Resident #66. Interview with RN #6 on 3/20/25 at 1:54 PM identified that on 3/17/25, Resident #66's hemolytic communication book was never sent. RN #6 further identified that the policy of the hemolytic center required that the only medication given during treatments were the medications prescribed by the dialysis center physician. Medications that were sent with Resident #66 had to be self-administered by the resident and were not documented on the hemolytic treatment records. RN #6 could not confirm if Resident #66 had taken the medication sent or not. Additionally, the hemolytic center was not allowed to supply Resident #66's facility prescribed medications. Interview with APRN #1 on 3/20/25 at 2:29 PM identified that she was unaware that hydralazine was being placed in a handwritten plastic pouch to accompany Resident #66 to treatment at the center. She further identified that she was unaware the center's nurse would not administer the medication to Resident #66 and that Resident #66 would have to self-administer. APRN #1 indicated she would discontinue the medication, and indicated she had concerns about Resident #66's poor decision making abilities. APRN #1 identified she requested the Psychiatric APRN to see Resident #66 to evaluate Resident #66's decision making ability. Interview on 3/20/25 at 2:43 PM with Pharmacist #1 identified the facility failed to request packaging from the pharmacy for the medication to be sent with Resident #66 to his/her treatment center. If the facility had requested alternate packaging, Resident #66 could have properly packaged containers of his/her medication, and that the pharmacy would have been able to accommodate packaging in the form of Leave of Absence (LOA) packaging. Interview on 3/20/25 at 3:30 PM with Director of Nursing (DNS) and Administrator identified that Resident #66's communication binder accompanied Resident #66 to hemolytic treatments. The binder included a transfer sheet, consult sheet, and his/her medication list. The DNS indicated that the medication should have been packaged as an LOA medication from the pharmacy and that the medication should not have been removed from Resident #66's blister card and placed in a plastic pouch with handwritten identification. The DNS did not know why the medication was improperly packaged. The DNS stated that he was unaware the hemolytic treatment center would not administer the medication sent and that Resident #66 had to self-administer. The DNS additionally identified the facility failed to complete a self-administration assessment because he did not feel Resident #66 was appropriate to self-administer medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing home hemolytic agreement, in part, identified the center shall have the sole responsibility for administering hemolytic treatments to a designated resident, providing intra-dialytic medication to designated residents as ordered by such designated Resident's nephrologist and providing ESRD related lab tests to the designated resident. The center will provide only hemolytic treatment services to the designated residents and will perform no other services, medical or otherwise, except as such services are related to or are an integral part of the provision of hemolytic services. Review of the facility out on pass/leave of absence policy dated November 2021 directed the charge nurse on duty assures that residents have their necessary medications before leaving the facility on pass or therapeutic leave of absence. When receiving a physician's order for a resident to go out on pass, the charge nurse on duty reviews the resident's medication orders and directions for use with the physician and determines if pass medications are needed. If the resident's physician concurs and gives an order to do so, the physician's order should list the medications to be dispensed for the leave of absence including controlled substances. All medications provided to the resident and/or responsible party for administration while on pass are properly labeled by the pharmacy with full directions for use. Review of the revised Self-Administration of Medication policy dated July 2023 directed residents who request self-administer medications will be assessed for capability. If it is determined whether the resident is able to self-administer a physician order is required, self-administration must be care planned, residents must be instructed in self-administration, and periodic evaluations of capability must be performed. 2. An observation of a medication cart on the Pavillion Unit on 3/20/25 at 9:53 AM identified that LPN #1 had locked her narcotic keys in the top right-side drawer of the medication cart. An interview with LPN #1 on 3/20/25 at 9:53AM identified she was not aware that the narcotic keys for the medication cart could not be locked in the medication cart and needed to be kept on her person. Subsequent to surveyor inquiry, LPN #1 removed the keys from the medication cart and placed them in her pocket. An interview with the Director of Nursing on 3/20/25 at 10:30AM identified that nurses must always keep narcotic keys always from other keys and the nurse must keep the narcotic keys on his/her person. He stated that the narcotic keys could not be locked in the medication cart. 3. Interview with Assistant Director of Nursing (ADNS) on 03/20/25 10:35AM identified that she was not completing bimonthly narcotic audits (twice monthly reconciliation of narcotics) on the units. She indicated that she was not aware it was her responsibility to complete the audits as she had never been instructed to do so or educated how to do so by the DNS. The ADNS stated she kept a copy of the Controlled Substance Disposition Record for every individual resident in the facility that was prescribed a narcotic. The pharmacy sends one copy of the Controlled Substance Disposition Record, and the charge nurse or supervisor makes a copy for the ADNS files. The ADNS stated when the unit Controlled Substance Disposition Record copy comes back to the office and the medication has been used up, she matches the sheet with her copy and files both copies in her office. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 3/20/25 at 10:45AM identified that he was not aware that the ADNS was not completing the bimonthly narcotic audits. He stated that he had not completed any bimonthly narcotic audits on the units since he started his position 18 months ago. The DNS was unable to state if he had reviewed how to complete bimonthly narcotic audits with the ADNS. 4. Interview with the DNS on 3/20/25 at 10:50AM identified that he stored unused narcotics for destruction in a double locked cabinet in his office. The DNS indicated that he does not keep a log (accountability record) of the narcotics after receiving discontinued or discharged resident narcotic medications. He stated that when narcotics are received from the nursing units for destruction, he counts the number of narcotics received in the medication blister pack with the nurse returning the narcotics, they verify the number of medications, and both sign off on the Controlled Substance Disposition Record. He then wrapped the Controlled Substance Disposition Record around the blister pack container, placed a rubber band around both and stored the items in the double locked cabinet. The DNS indicated that he was unaware that the Controlled Substance Disposition Record could not be kept with the narcotic blister pack. A review of the Medication distribution and control policy dated July 2023 directed, in part, the access system to controlled medications is not the same as other medications. The key system that opens the medication cart differs from the key that opens the narcotic compartment. The narcotic keys are kept on a separate key ring and the medication nurse on duty always maintains possession of the key ring to the controlled substance area. A review of the Medication Storage in the Facility policy dated November 2021 directed, in part, controlled substance inventory is regularly reconciled to the Medication Administration Record. Controlled substances remaining in the facility after the order has been discontined or the resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed. Accountability records for discontinued controlled substances are maintained with the unused supply until they are disposed of or destroyed. 51756

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on observations, review of clinical records, facility documentation, facility policy, and interviews for 2 of 3 sampled residents (Resident #20 and Resident #47) reviewed for medication administration, the facility failed to ensure that the medication error rate was less than 5% and for 1 of 5 sampled units, Pavillion Unit, for Residents #1, #24, #37, #79, #65, #60, #45, #72, #31, #78, and # 27, the facility failed to ensure medications were administered at the correct time per the physician's orders. The findings include: 1. Resident #20's diagnoses included paranoid schizophrenia, anxiety, acute angle closure glaucoma, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 as being cognitively intact. Physician's orders dated 1/10/25 directed to administer Coreg 12.5 mg (milligrams) 1 tablet (tab) 2 times a day and hold for a heart rate less than 50, Pilocarpine Solution 1% 1 eye drops to both eyes 3 times a day, and Trazadone HCL 100 mg give one tab 2 times a day. Observation on 3/17/25 at 10:05 AM with LPN #1 during medication administration for Resident #20 identified that Resident #20's 8:00 AM medications were administered at 10:05 AM, an hour and 5 minutes after the allowed timeframe. 2. Resident #47's diagnoses included atrial fibrillation and heart failure. The quarterly MDS assessment dated [DATE] identified Resident #47 as being cognitively intact. Physician's orders dated 2/5/25 directed to administer Eliquis 2.5 mg give 1 tab 2 times a day and Metoprolol Succinate 100 mg extended release give 1 tab 2 times a day. Observation on 3/17/25 at 10:30 AM of medication administration with LPN #1 for Resident #47 identified that Resident #47's 8:00 AM medications were administered at 10:30 AM, an hour and a half after the allowed timeframe. An interview with LPN #1 on 3/17/25 at 10:30 AM indicated that medication administration on the unit was very difficult to complete timely. She indicated that although she is a regular nurse on the unit for the 7:00 AM to 3:00 PM shift, she is unable to complete the morning medication pass before 11:00 AM. Furthermore, LPN #1 indicated that she has made nursing administration (DNS/ADNS) aware of late medication pass several times. Due to the late administration, (wrong time) the facility medication error rate was 15.6%. Observation on 3/17/25 at 10:50 AM, LPN #1 was still administering 8:00 AM and 9:00 AM medications on the East Unit. The ADNS indicated that the providers would be notified of any residents that received medications late. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADNS identified that Resident #1, Resident #24, Resident #34, Resident #37, Resident #65, Resident #60 Resident and Resident #79 (who had medications ordered for 8:00 AM and 9:00 AM) received their morning medications after 11:00 AM. 3. Resident #1's diagnoses included COPD, Hypertension and bipolar disorder. The quarterly MDS assessment dated [DATE] identified Resident #1 as being cognitively intact. Physician's orders dated 2/10/25 directed to administer Potassium Chloride liquid 20 milliequivalents (mEq) 2 times a day, benztropine 0.5 mg 2 times a day, cranberry tabs 450 mg 2 times a day, Ascorbic Acid 500 mg 2 times a day, Divalproex delayed release 125 mg 2 times a day, and Eliquis 2.5 mg 2 times a day. 4. Resident #24's diagnoses included chronic kidney disease, gastrointestinal bleed, and Chronic Obstructive Pulmonary Disease (COPD). The annual MDS assessment dated [DATE] identified that Resident #24 was cognitively intact. Physician's orders dated 1/24/25 directed to administer Baclofen 5 mg tab give 2 times a day, Metoprolol Tartrate 25 mg give 2 times a day, Mucus relief 600 mg extended release give 2 times a day. 5. Resident #34 diagnoses included Sjogren syndrome (autoimmune disease), hypertension, and heart disease. The quarterly MDS assessment dated [DATE] identified Resident #34 as being cognitively intact. Physician's orders dated directed to administer Chlorhex Solution 0.12% 5 ml (milliliters) 2 times a day, Clear eye drops 0.5-0.6% 1 drop both eyes 2 times a day, Clonazepam 0.25 mg 2 times a day, Fluticasone 50 mcg (micrograms) 2 sprays each nostril 2 times a day, Gabapentin 300 mg capsules 2 times a day, and Xiidra 5% instill 1 drop in both eyes 2 times a day. 6. Resident #37's diagnoses included hypertension with chronic kidney disease, heart failure, and dementia without behavioral disturbances. MDS assessment date 12/20/24 identified Resident #37 as having severe cognitive impairment. Physician's orders dated 1/15/25 directed to administer Gabapentin 300 mg 3 times a day, Metoprolol Tartrate 50 mg 2 times a day, Pantoprazole 40 mg 2 times a day. Potassium Chloride 20 mEq extended release give 2 tabs, 2 times a day, Sucralfate 1 GM (gram) give 4 times a day. 7. Resident #60's diagnoses included chronic kidney disease, alcoholic polyneuropathy, and hypertension. The quarterly MDS dated [DATE] identified Resident #60 as being cognitively intact. Physician's orders dated 1/30/25 directed to administer Ferrous Sulfate 325 mg 2 times a day, Phos-Nak oral packet 280-160-150 MG (potassium and sodium phosphate) 1 packet by mouth 2 times a day, and Veltassa Powder 8.4 GM give one packet 3 times a day (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Resident #65's diagnoses included coronary artery disease, heart failure, and dementia. The quarterly MDS assessment dated [DATE] identified Resident #65 as having severe cognitive impairment. Physician's orders dated 2/12/25 directed to administer Carvedilol 25 mg 2 times a day, MiraLAX 17 gm (grams) with water 2 times a day, Senna S 8.6 mg give 2 tabs, 2 times a day, Acetaminophen 500mg give 2 tabs, 2 times a day, Oxycodone HCL 5 mg 3 times a day, Lactulose 30 ml 2 times a day and Lantus Solostar pen injector 100 unit/ml give 34 units SC (subcutaneously) 2 times a day. 9. Resident #79's diagnoses included COPD, hypertension and anxiety disorder. The quarterly MDS assessment dated [DATE] identified Resident #79 as having moderately cognitive impairment. Physician's orders dated 1/30/25 directed to administer Metformin 500 mg 2 times a day. Interview with APRN #1 on 3/17/25 at 3:00 PM identified that the facility had notified her of all the residents that received medications late for the morning medication pass on 3/17/25. She indicated that there were no significant concerns related to late administration and there were no orders. On 3/26/25, RN #4 identified that Resident #27, Resident #31, Resident #45 Resident #72, , Resident #78, and did not receive their AM medications within the given timeframe. 11. Resident #27's diagnoses included epilepsy, type 2 diabetes, and failure to thrive. The annual MDS assessment dated [DATE] identified Resident #26 as having moderate cognitive impairment. Physician's orders dated 2/15/25 directed to administer Xifaxan 550 mg 2 times a day and Gabapentin 300 mg 3 times a day. A review of facility documentation identified that Xifaxan and Gabapentin were administered at 2:24 PM. Xifaxan was administered 4 hours and 24 minutes after the allowed administration timeframe. Gabapentin was administered 1 hour and 24 after the allowed scheduled administration timeframe. 12. Resident #31's diagnoses included dementia, heart failure and type 2 diabetes. The MDS assessment dated [DATE] identified Resident #31 as having severe cognitive impairment. Physician's orders dated 1/16/25 directed to administer Novolog Flex Pen 100 unit/ml give 4 units, Trazadone 25 mg once a day at 12: 00 PM, Gabapentin 600 mg 3 times a day. Review of facility documentation on 3/27/25 identified that NovoLog insulin, Trazadone and Gabapentin were administered at 2:55 PM, 1 hour and 55 minutes after the scheduled administration timeframe. 13. Resident #45's diagnoses included dementia with agitation, type 1 diabetes and hypertension. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #45 as having severe cognitive impairment. Physician's orders dated 1/20/25 directed to administer Novolog Flaxen 100 unit/ml insulin, inject 3 units SC at lunch time and Hydralazine 15mg 3 times a day. A review of facility documentation on 3/27/25 identified that the Novolog insulin and Hydralazine were administered at 2:41 PM, 2 hours and 41 minutes after scheduled administration time. 14. Resident #72's diagnoses included dementia, hypertension and failure to thrive. The quarterly MDS assessment dated [DATE] identified Resident #72 as having severe cognitive impairment. Physician's orders dated 2/15/25 directed to administer Hydralazine 100 mg 3 times a day. A review of facility documentation on 3/27/25 identified that Hydralazine was administered at 2:42 PM, 2 hours and 42 minutes after scheduled administration time. 15. Resident #78's diagnoses included dementia, hypertension, and depressive episodes. The quarterly MDS assessment dated [DATE] identified Resident #26 as having severe cognitive impairment. Physician's orders dated 1/5/25 directed to administer Trazadone 25 mg once a day at 12:00 PM. A review of facility documentation identified that Trazadone was administered at 1:59 PM, 59 minutes after the allowed scheduled administration timeframe. Interview with APRN #1 on 3/26/25 indicated that she was aware of late medication pass and any medication errors that may have occurred. APRN #1 indicated that the late medications were not significant medication errors. A review of the Administration of Medications Policies and Procedures policy dated 7/23 directed, in part, medication errors and adverse drug reaction shall be immediately reported to the attending physician, charted in the clinical records and described in the Medication Error Report. Medications are to be given at the time ordered or within 60 minutes before or after the time designated.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 11 sampled residents (Resident #48) observed in the east dining area during meals, the facility failed to provide adaptive equipment as identified on the meal ticket. The findings include: Resident #48's diagnoses included Parkinson's disease, severe dementia with anxiety, and adult failure to thrive. The annual Minimum Data Set assessment dated [DATE] identified Resident #48 was severely cognitively impaired and required substantial maximum assistance with eating and was dependent on staff for personal hygiene, dressing, toileting, bed mobility, and transfer. The Resident Care Plan dated 1/23/25 identified Resident #48 had a dementia diagnosis which could affect appetite/intake, has a history of significant weight loss, is taking psychotropic medications which can affect appetite/intake, and used adaptive equipment to help with independent eating. Interventions included diet as ordered, provide adaptive equipment, personal sippy cup, built up spoon, lip plate, and supervise the resident with meals. An Occupational Therapy note dated 3/2/25 at 4:16 PM identified self-feeding with minimal assistance. Resident #48 was able to perform 75% or more of the activity but requires weight bearing assistance from 1 caregiver to complete. An interview on 3/20/25 at 10:55 AM with a family member identified that Resident #48 does not always have drinks and silverware when the family member observed Resident #48 in the dining room. The family member stated that when they had previously gone to the staff with their concerns about drinks and adaptive equipment, the staff seemed unaware of Resident #48's needs. The family member further indicated that the Director of Nursing had been made aware of the lack of drinks and silverware. Observation on 3/20/25 at 5:40 PM identified NA #18 assisting Resident #48 to eat. The meal ticket next to the resident indicated that Resident #48 was to have a built up curved gray spork and handled cup with a straw. The sippy cup was not available, and the built-up spork was noted in a plastic bag on the delivery cart not being utilized by the resident. Interview with NA #18 identified that she was unaware Resident #48 required adaptive equipment for eating. Review of the meal ticket with NA #18 indicated the adaptive equipment required (built up, curved gray spork, lip plate, and a handle cup with a straw). Interview on 3/20/25 at 5:40 PM with LPN #9 identified that Resident #48 would decide whether he/she was going to eat independently or wanted staff to assist. LPN #9 further indicated that she thought Resident #48 needed to be assisted with all his/her meals. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Food Service Director on 3/20/25 at 5:50 PM identified that resident adaptive equipment was placed on the silverware carts and labeled with the resident's name on a plastic bag containing the adaptive equipment and adaptive equipment was identified on the meal tickets. NAs distribute adaptive equipment when serving the residents their meal. Observation on 3/21/25 at 12:15 PM identified Resident #48 was in the dining room with a family member present. Resident #48 was without the benefit of a sippy cup. The Occupational Therapist was present and began working with Resident #48 for self-feeding. Review of the Dining Tray ticket policy directed, in part, the purpose of dining tray tickets is to ensure that residents receive the correct meals according to their dietary preferences, restrictions, and needs. A tray card is prepared with the resident's name, room number, diet order, food allergies, food preferences, portion sizes, and adaptive equipment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on tour of the Dietary Department, staff interview and facility policy, the facility failed to ensure kitchen equipment was maintained in sanitary manner, failed to ensure open food items were dated to include dates opened/expired/use by, and failed to recheck temperatures of a resident's reheated food. The findings include: 1. Tour of the Dietary Department kitchen on [DATE] at 10:15 AM with the Food Service Director (FSD) identified the following: a. A heavy accumulation of white and brown debris/lint on the juice machine vent located on the upper front section of the chiller/juice machine. b. A heavy accumulation of congealed black and brown burnt residue on the stove, and surrounding surfaces. c. A large amount of white and brown congealed buildup on the conventional oven doors. An interview on [DATE] at 10:30 AM with the FSD identified that kitchen staff only clean the outside/surface of the juice machine, but the facility use a contracted company for a comprehensive cleaning of the machine every 3 months and as needed. The FSD indicated that the company last serviced and cleaned the juice machine in December of 2024, but she was unable to provide documentation of the visit. She stated that the machine needed to be taken apart for the vent section to be cleaned, it was her responsibility to inform the chiller machine company to come in for a comprehensive cleaning, but she had not done so for quite some time. The FSD also indicated that dietary staff were responsible for wiping down the stove daily after use and thoroughly cleaning it monthly using a decreasing agent. The FSD stated that it seemed someone spilled something on the stove over the weekend and it was never cleaned. Additionally, she identified that even though the oven was cleaned every week, an accumulation of residue in between the glass doors could not be cleaned by staff and indicated that the oven glass doors needed to be taken apart to access the accumulated residue on the inside of the glass doors. The FSD identified that the Maintenance Department would be requested to help with taking apart the oven door and kitchen staff would perform the cleaning. The FSD indicated she was responsible for ensuring cleaning tasks were completed. The facility General Cleaning Guidelines directed the cleaning and sanitization of most equipment and surfaces in the kitchen included: the daily cleaning the stove including the loosening of baked on grease or carbonized food with a stiff bush or scraper as needed, spraying with cleaner, and wiping until the surface is restored. 2. Observation and interview of the dry storage room with FSD on [DATE] at 11:44 AM identified an opened 5 pound (lb.) bag of yellow cake mix (that was ,d+[DATE] full). The bag was not labeled/dated when opened. There were 6 unopened 5 lb. bags of yellow cake mix that were out their original boxes with no expiration date or label, and a 5 lb. bag of pasta (that was ,d+[DATE] full) with no open date or expiration date. The FSD indicated that all food items that are opened or taken out of their original boxes or containers needed to be labelled with an open date and/or an expiration date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Date Marking policy dated [DATE] directed, in part, that foods will be date marked with the name of the product, the date of the production or opening and referenced to a quick reference list for discard date. A designated employee will be assigned to monitor products within the department and the process will be monitored by the FSD. 3. Observation and Interview with NA #4 on [DATE] at 9:30 AM identified that she brought a resident's tray into the nourishment room to reheat the food per the resident request. NA #4 indicated that she asked residents if they needed any items or their food reheated when delivering meal trays, and if a resident requested food to be reheated, she would use the microwave in the nourishment room to heat the food for about 30 seconds. She would then place the back of her hand over and above the food to gauge how warm the food was before adding additional reheating time. Observation of the nourishment room failed to identify a thermometer located in the room. Interview with the FSD on [DATE] at 11:47 AM identified that nursing staff were permitted to reheat food. The FSD further indicated that food was to be heated until the temperature was 165 degrees Fahrenheit and verified by the thermometer in the nourishment room. FSD was notified that there was no thermometer in the nourishment room. Review of the Reheating Food Policy identified that all reheated food must reach 165 degrees Fahrenheit for at least 15 seconds and would be verified by use of a thermometer to check the internal temperature. Reheated food should be served immediately or held at 135 degrees Fahrenheit or above until served. If using a microwave, food should be heated to 165 degrees Fahrenheit, covered, stirred, and allowed to stand for even heating.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 50179 51182 Based on observation, clinical record review, facility documentation, facility policy, and interviews, the facility failed to administer its resources effectively and to ensure timely and effective administrative oversight of staff and resident care to maintain the highest practicable physical, mental and psychosocial well-being of residents. The findings include: The facility administration failed to: Ensure the State Agency was notified, in a timely manner, of reportable events Ensure allegations of abuse were investigated timely and thoroughly Ensure staff accused of abuse were removed from the schedule timely Ensure residents were provided with an environment free from involuntary seclusion. Ensure medications were administered timely and according to professional standards. Ensure narcotics were properly stored and bimonthly narcotic audits were performed. Ensure the clinical record was complete and accurate. Ensure staff received adequate training per federal guidelines. Ensure residents were provided with a sufficient number of clean bed and bath linens. Ensure care plans were reviewed, updated timely, and included resident participation. Ensure the kitchen was maintained in a sanitary condition and maintained food items required for a 3 day emergency supply. Please cross reference F584, F600, F603, F607, F609, F610, F658, F684, F755, F759, F812, F943, F944, F946, F949. Based on the deficiencies during the survey, immediate jeopardy and substandard care were identified in the areas of: Freedom from Abuse, Neglect, and Exploitation; Quality of Care; and Training Requirements. Interview on 3/19/25 at 9:45 AM with the Director of Nursing Services (DNS) and the Administrator identified that the Administrator was aware that an allegation of staff-to-resident abuse was made on 1/3/25, that the State Agency (SA) was not notified of the Reportable Event (RE), and the DNS created a summary on 3/18/25 for the event that happened on 1/3/25 to present to the state agency. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/20/25 at 8:36 AM with the DNS and Administrator identified that the Administrator failed to provide adequate oversight of the DNS in ensuring the reporting of an allegation of abuse was submitted to the SA and that the facility's policy for reporting was followed, following a conversation on 3/20/25 at 8:36 AM at which time both the DNS and Administrator were informed of the lack of reporting and lack of starting an investigation for an incident on 1/3/25. The Administrator was responsible for signing the Reportable Events. Interview on 3/27/25 at 9:46 AM with the Administrator, Regional Registered Nurse (RN) #4, and Regional Registered Nurse (RN) #8 identified that although the Administrator stated he met with the DNS on a weekly basis, he failed to keep a record of those conversations in meeting minutes, his personal notes, or email correspondences. Further, the Administrator was aware the facility had no ethics or compliance policy, nor did the facility discuss issues pertaining to resident abuse in Quality Assurance and Performance Improvement meetings. The facility failed to utilize resources effectively to attain/maintain the resident's well-being. Review of the Administrator Job Description identified the responsibility of the Administrator was to plan, organize, develop, direct, control and supervise the overall operations of the facility in accordance with current federal, state, and local laws, regulations, standards and guidelines, and to ensure the highest degree of quality resident life is maintained.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, clinical record review, review of facility policy, and interviews for 2 of 6 sampled residents (Resident #43 and Resident #46) for Resident #43 reviewed for abuse and Resident #46 reviewed for falls, the documentation failed to correctly reflect actual events. The findings include: 1. Resident #43's diagnoses included dementia, chronic kidney disease, and hypertensive heart disease with heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 was cognitively intact, did not experience episodes of delusions, and required maximal assistance for his/her toileting hygiene and chair to bed and bed to chair transfers. The Resident Care Plan (RCP) in effect on 1/3/25 identified Resident #43 experienced frequent episodes of incontinence of bladder with an intervention of an assist of 2 with toileting upon request. The Resident Care Card in effect on 1/3/25 identified Resident #43 was to have 2 staff members present at all times when in his/her room including when performing bathing and toileting tasks. An interview with Resident #43 on 3/18/25 at 11:51 AM was conducted by the surveyor in the presence of the DNS. Resident #43 alleged a few weeks prior that while he/she was trying to get into bed from his/her wheelchair, LPN #7 reached over the back of the wheelchair and pushed him/her onto the bed in a non-sexual manner. Resident #43 further identified that he/she was alone in the room with LPN #7 and started yelling for help, at which point LPN #7 grabbed the phone out of his/her hand and threw it across the room. It was noted by Resident #43, that Nurse Aide (NA) #7 entered the room and assisted him/her into bed for the provision of incontinence care. Resident #43 stated she experienced great humiliation over the event and continued to be afraid of LPN #7, noting LPN #7 continued to come into his/her room to provide care after the alleged incident of abuse. The Director of Nursing Services (DNS) identified he was aware of the allegation of abuse and stated he had completed an investigation and reported the incident to the State Agency (SA). An interview and review of abuse documentation with the DNS on 3/19/25 at 7:51 AM failed to produce investigation documentation following the 1/3/25 incident. The DNS, in lieu of investigation documentation, provided an undated and unsigned summary of the incident. The DNS stated the summary was created at the time of his investigation. An interview with the DNS and Administrator on 3/19/25 at 9:45 AM identified the summary of the alleged abuse event was not created at the time of the investigation but instead created on 3/18/25. A review of the DNS's undated summary of the 1/3/24 allegation of abuse created on 3/18/25 inaccurately identified Resident #43 was admitted on [DATE], was [AGE] years old, had a BIMS of 13, had a diagnosis of dementia with behavioral disturbances, and wanted to be changed for incontinence care during the 1/3/25 incident. Further, the DNS summary stated the DNS assessed Resident #43 for injuries of any kind and there were no new areas or signs of injury. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Contrary to the DNS statement, a review of Resident #43's MDS dated [DATE], in effect at the time of the 1/3/25 allegation of abuse, identified that Resident #43 was admitted on [DATE], was [AGE] years old, and had a BIMS of 15, an inaccurate account of Resident #43's information. A review of Resident #43's facility face-sheet dated 3/19/25 identified an admitting diagnosis of dementia without behavioral disturbance. A review of Resident #43's progress notes from 1/3/25 through 1/10/25 identified there were no progress notes or assessments for Resident #43 documented by the DNS within the electronic medical record for the 1/3/25 allegation of abuse. An interview on 3/19/25 at 4:26 PM with LPN #7 identified that Resident #43 declined incontinence care the shift previous to his shift with him/her on 1/3/25. LPN #7 further indicated that Resident #43 declined incontinence care during his shift, and he informed the resident he/she had to be changed. LPN #7 stated that Resident #43 was crying and yelling for help during the provided incontinence care, and he removed the phone from his/her hand and told Resident #43 he/she could call for help when he was done. LPN #7 stated the reason he made the late entry nurses note regarding the incident 2 days after it occurred was he was advised to do so by the DNS to protect himself. The DNS's summary document indicated that Resident #43 had wanted to be changed. Review of an email dated 3/20/25 at 1:23 PM from LPN #7 to the DNS identified Resident #43 refused incontinence care twice during his shift on 1/3/25 and he instructed the NA to perform care to which Resident #43 had been opposed. A review of the Reportable Event Form, submitted on 3/20/25 for the allegation of abuse occurring on 1/3/25, incorrectly identified the event type to be resident to resident abuse without injury, the age of Resident #43 to be [AGE] years old (resident was [AGE] years old), date of admission to be 2/9/24 (date of admission was 10/10/23), and that the resident had no injury, distress, or discomfort. 2. Resident #46 diagnoses included generalized muscle weakness, heart failure, cerebral palsy, contracture of muscle, right upper arm and mild intellectual disabilities. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 5), was dependent on staff for toileting and personal hygiene and required maximum assistance for toilet transfers. The MDS identified Resident #46 with an impairment on one side of his/her upper extremity and further identified that he/she ambulated in a wheelchair. The Resident Care Plan (RCP) dated 10/21/24 identified Resident #46 was at risk for falls related to impaired mobility. Interventions included, ensuring Resident #46 was wearing appropriate footwear while mobilizing in his/her wheelchair, following facility fall protocol, placing call light within reach and encouraging Resident#46 to use it for assistance as needed. The Resident Care Card (RCC) for the month of March 2025 identified Resident #46 was at risk of falls and required assistance of 1 staff for personal care, bed mobility, and stand pivot transfers and wheelchair for mobility. The Reportable Event form dated 11/16/24 at 12:30 PM identified Resident #46 was with Nurse Aide (NA#5) in the bathroom being toileted, Resident #46 lost his/her grip on the grab bar, slipped to the right and struck his/her head on the wall. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	A Post Fall Assessment form completed identified Resident #46 was oriented to person and place. The Post Fall assessment further identified a gait imbalance during transfer as the predisposing physiological factor related to the incident. RN #3's nurse's note dated 11/16/24 at 5:29 PM identified that Resident #46 was being toileted by NA #5 when she/he became unsteady and leaned over placing the right side of his/her head on the wall. Resident #46 did not complain of pain at the time of the incident and no marks or bruises were observed. Vital signs and neuro vital signs were initiated, and Resident #46's family member and physician were notified. A DNS late entry nurse's progress note dated 11/18/24 at 7:31 AM dated back to 11/16/24 at 1:02 PM, identified that he was called to Resident #46's room related to a witnessed fall in bathroom. The DNS indicated that according to NA #5 while she was transferring Resident # 46 to the toilet, he/she became weak and leaned against the wall. The DNS identified that Resident #46 was lowered to ground by NA #5 with a gait belt, to sitting then lying position. The note identified that when Resident#46 leaned against the wall initially his/her head hit the wall. Additionally, the note identified that neurological, vital signs, a head to toe assessment, and range of motion were all within normal limits and Resident #46 did not lose consciousness. The note indicated that Resident #46 denied pain and there was no injury or new skin issue noted, and that two staff members assisted Resident #46 back to the toilet to finish using bathroom as originally intended. Interview with NA #5 on 3/19/25 at 11:06 AM, identified that she responded to Resident #46's call light, and he/she requested to be assisted to the bathroom urgently. NA #5 indicated that she did not have a gait belt and assisted Resident #46 to the bathroom without using a gait belt. NA #5 stated that when Resident #46 stood up, he/she lost her grip on the pull bar and hit the right side of his/her head on the wall. NA #5 identified that she managed to safely assist Resident #46 to the toilet and stayed with him/her until he/she was done, then transferred him/her back to wheelchair safely without the use of a gait belt. NA #5 further indicated that she wheeled Resident #46 to the nurse's station and reported the incident to RN #3. NA #5 stated that she completed a paper incident report and handed it to RN#5. NA#3 identified that Resident #46 did not fall during transfer in the bathroom but only bumped his/her head on the wall. NA #5 further identified that the DNS did not respond to the incident in Resident #46's bathroom, nor had he interviewed her regarding the bathroom accident with Resident #46. Interview on 3/19/25 at 2:50 PM with DNS identified that he responded to Resident #46's bathroom incident but could not recall details of the incident. The DNS was unable to explain if he responded to the incident in person as he stated in his progress note regarding the incident or whether his documentation was based on an interview with NA #5 and RN #3. The DNS indicated that he would seek clarification from RN # 3 and NA#5. Interview with RN #3 on 3/25/25 at 2:37 PM identified that she assessed Resident #46 after the bathroom accident with NA #5. RN #3 identified that Resident #46 was not lowered to ground by NA #5 with the use of a gait belt as indicated in the DNS progress note. RN#3 further identified that the DNS was not present when she assessed Resident #46. The DNS's documentation failed to describe an accurate representation of Resident #46's incident and actual experience in the bathroom. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the facility's Charting and Documentation policy, identified in part, that documentation in the medical record will be objective (not opinionated or speculative), complete and accurate, and be completed for treatments or services provided and for events, incidents, or accidents involving the resident. 51182

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 51182 Based on staff interviews, facility policy, and documentation reviewed for the facility Quality Assurance Improvement Plan (QAPI), the facility failed to include the Infection Preventionist in the Quality Assessment and Assurance (QAA) meetings. The findings include: An interview on 3/20/25 at 10:20 AM with Licensed Practical Nurse (LPN) #9 identified she began her oversight of the Infection Prevention program around September/October of 2024. An interview and QAPI documentation review with the Administrator on 3/24/25 at 11:13 AM identified the facility meets on a monthly basis for QAPI/QAA meetings. A review of the meeting sign-in sheets with the Administrator identified meetings were held in July 2024, August 2024, September 2024, October 2024, November 2024, December 2024, and January 2025. Although the Infection Preventionist did attend the January 2025 meeting she failed to attend the meetings in July through December of 24 (missing 6 of 7 opportunities for attendance). The Administrator indicated the reason an Infection Preventionist did not attend the QAPI/QAA meetings was due to staffing issues, with the prior Infection Preventionist resigning her position in August 2024, and the facility's current Infection Preventionist not being hired immediately after August 2024. The Administrator noted that although some staff are shared between facilities within the parent organization, the Infection Preventionist position is not shared. Review of the facility's QAPI policy identified the facility will establish an interdisciplinary QAPI committee. The committee shall consist of a minimum of the Administrator, Director of Nursing, Medical Director, and three other staff members. The QAPI policy failed to identify that per Federal guidelines, an Infection Preventionist must be included in the QAPI committee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, clinical record review, review of facility policy, and interviews for 1 of 3 sampled residents (Resident #4) reviewed for pressure ulcers, the facility failed to ensure appropriate Personal Protective Equipment (PPE) was worn prior to personal care, for 1 of 5 sampled resident units (for Resident #96, Resident #404, and Resident #407) reviewed for infection control practices, for Resident #96, failed to implement the appropriate precautions for an active Multi-Drug Resistant Organism (MDRO) and failed to perform appropriate hand hygiene during wound care for Resident #404, failed to ensure appropriate PPE was worn upon entering the resident's room and failed to implement appropriate precautions for an active MDRO, and for Resident #407 failed to ensure appropriate hand washing for a resident with an active MDRO. The findings include: 1. Resident #4's diagnoses included dementia, generalized muscle weakness, anxiety, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had severe cognitive impairment (Brief Interview for Mental Status (BIMS) score of 5), and was dependent on staff for toileting hygiene, personal hygiene, transfers and required maximum assistance for bed mobility. The MDS identified that Resident #4 had impairment on both sides of the upper and lower extremities and was always incontinent of urine and bowel. The Resident Care Plan in effect for the month of March 2025 identified Resident #4 was on Enhanced Barrier Precautions (EBP). Interventions included maintaining EBP per facility policy and observing for signs and symptoms of infection and reporting accordingly. The care card (NA Resident Assignment) identified EBP was in place and directed staff to wear a gown and gloves when delivering direct care to Resident #4. Observations on 3/20/25 at 10:30 AM, identified EBP signage on the right side of the wall outside of Resident #4's room directing to wear gloves and a gown for high contact resident care (dressing, bathing, changing linen, device care and wound care) and a precaution cart stocked with gloves and gowns was present on the opposite side of Resident #4's room in the hallway. Further, NA #10 and NA #11 were in Resident #4's room providing incontinent care wearing gloves but without the benefit of gowns. Interview on 3/20/25 at 11:00 AM, with NA #10 and NA #11 identified that they were not aware that Resident #4 was on EBP precautions. Although NA #10 and NA #11 were aware of the EBP sign posted outside Resident #4's room and the yellow dot indicating EBP next to Resident #4's name, they stated they were unaware that Resident #4 was on EBP and NA #11 indicated this was due to the precaution cart being located across the hall. Interview with RN #5 on 3/20/25 at 11:10 AM, identified EBP signage on the wall meant staff should wear personal protective equipment (gowns and gloves) with high contact activities such as providing personal care and transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Enhanced Barrier Precautions policy identified, in part, that the use of gowns and gloves for high contact resident care activities is indicated, when contact precautions do not otherwise, apply, in residents with wounds and/or indwelling devices regardless of MDRO colonization. 2. Resident #96's diagnoses included pressure ulcer of sacral region, neuromuscular dysfunction of bladder, and obstructive uropathy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #96 was cognitively intact, dependent on staff for toileting, hygiene and lower body dressing. Additionally, the MDS identified pressure ulcer/injury care was required. a. The Resident Care Plan dated 2/13/25 identified that Resident #96 was on Enhanced Barrier Precautions (EBP). Interventions included following precautions per the facility policy and monitoring for signs and symptoms of infection. A physician's order dated 3/17/25 directed staff to obtain a urinalysis with culture and sensitivity. A physician's order dated 3/18/25 directed to maintain EBP precautions every shift for a history of Methicillin Resistant Staph Aureus (MRSA). Observations intermittently throughout the day on 3/17/25, 3/18/25, and 3/19/25 identified Resident #96 had an EBP sign posted outside his/her room. Review of the clinical record identified that on 3/19/25 APRN #1 had reviewed the urinalysis culture and sensitivity results from the physician order dated 3/17/25. Resident #96 was noted to be positive for Extended-Spectrum Beta-Lactamase (ESBL) (an active Multi-Drug Resistant Organism (MDRO) infection) and ordered antibiotic treatment. Further review of the physician orders identified that although a culture sensitivity indicated an active MDRO, the orders failed to indicate the EBP (gloves and gown) had been changed to the appropriate contact precautions, gown and gloves, and in certain instances restriction of movement/precautions for the resident in the facility for an active MDRO infection. Observation on 3/20/25 at 10:47 AM identified the EBP sign had been removed and replaced with a contact precaution sign. In an interview with the Laboratory Customer Service Representative on 3/20/25 at 11:18 AM identified the laboratory had called Registered Nurse (RN) #1 on 3/17/25 at 12:17 PM and verbally notified her of Resident #96's positive ESBL result, in addition to the results being faxed to the facility. Interview with LPN #2 on 3/20/25 at 11:34 AM identified Resident #96 was changed to contact precautions by the Infection Preventionist (IP) on 3/20/25 in the morning due to something in his/her urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 3/20/25 at 11:41 AM identified it was the facility policy to notify the IP when a resident was identified to have an active MDRO, and if the MDRO was determined by lab work, RN #1 would provide the results to the IP and APRN so they could review the results and potentially obtain new physician orders. RN #1 identified she was knowledgeable of what an MDRO was, denied ever receiving a call from the lab with the positive ESBL results, but stated she had passed Resident #96's faxed laboratory results to the APRN. She failed to identify if she had reviewed the lab work result prior to providing the information to the APRN. Additionally, RN #1 identified that it was the responsibility of the Infection Preventionist to initiate the appropriate precautions. Interview with the Infection Prevention nurse (IP) on 3/20/25 at 1:11 PM indicated she identified positive laboratory and culture results through the nursing supervisor, who also notified the APRN and charge nurse. If results were positive for an active MDRO, it was the charge nurse's or RN supervisors' responsibility to initiate the appropriate precautions immediately. Additionally, she stated Resident #96 was not changed from EBP to contact precautions for the 3/17/25 positive ESBL result in his/her urine because the MDRO was not identified by any staff until this morning (3/20/25 3 days after the results were obtained) when she reviewed the results and changed Resident #96 to the appropriate contact precautions. Interview with APRN #1 on 3/20/25 at 1:57 PM identified she was aware of the laboratory result showing Resident #96 was positive for ESBL, and that is why she changed resident #96's antibiotic to one that was sensitive for ESBL. She stated that she had not initiated an order for contact precautions because that was the facility's responsibility. b. The Resident Care Plan dated 12/2/24 identified Resident #96 had a stage 4 pressure ulcer on the sacrum. Interventions included consultation and treatment by a wound nurse, and special mattress in place. The physician's order dated 3/6/25 directed for the pressure ulcer on the sacrum to be cleansed with hibiclens solution, patted dry, skin prep applied to the peri wound, followed by a silver alginate sheet to the wound bed, then cover with super absorbent dressing every shift. The physicians order dated 3/18/25 directed to maintain EBP precautions every shift for history of MRSA. Observation of the pressure ulcer dressing change with Licensed Practical Nurse (LPN) #2 and Nurse Aide (NA) #3 on 3/19/25 at 10:14 AM identified an EBP sign and precaution cart outside Resident #96's room. Both LPN #2 and NA #3 applied gloves and gowns without the benefit of hand hygiene prior. NA #3 assisted the resident onto his/her left side. LPN #2 prepared a sterile field, then removed her gloves and applied a new pair without the benefit of performing hand hygiene. LPN #2 opened Resident #96's brief, removed the dressing and provided him/her with peri care. She then removed her gloves and applied new gloves without the benefit of hand hygiene. LPN #2 performed the treatment per the physician's order, removed her gloves, then gown and washed her hands. NA #3 stayed with Resident #96 to assist with morning care. Interview with LPN #2 on 3/19/25 at 10:25 AM identified it was facility policy to perform hand hygiene between glove changes only when there was an active infection, otherwise it was not necessary. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the IP on 3/19/25 at 10:27 AM identified the hand hygiene policy was to perform hand hygiene between glove changes. 3. Resident #404's diagnoses included chronic obstructive pulmonary disease, cough, and esophageal obstruction. The hospital Plan of Care Summary dated 3/3/25 identified Resident #404 was on contact precautions for MRSA in the wound and lower respiratory tract. The baseline Resident Care Plan dated 3/6/25 identified Resident #404 had Methicillin-Resistant Staphylococcus Aureus (MRSA), colonization (not an active MRSA infection). Interventions included contact isolation, bagging and transporting used linen according to facility protocol prevent skin exposure or contamination and a provide a private room. The New Admission Alert dated 3/6/25 identified Resident #404 was MRSA positive (had an active infection). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #404 was cognitively intact and required partial/moderate assistance from staff for toileting, transfers, and personal hygiene. The MDS failed to identify that Resident #404 had an MDRO. A physician's order dated 3/12/25 directed to ensure MRSA droplet (sputum) precautions; place a sign and cart outside room, and wear gown and gloves every shift as instructed. Review of nurses notes from 3/7/25 through 3/18/25 intermittently identified both an active and colonized MRSA infection. Observations on 3/17/25 at 9:17 AM, 3/18/25 at 11:37 AM and 3/18/25 at 11:44 AM identified Enhanced Barrier Precaution (EBP) signage outside Resident #404's room. The sign directed gloves and gown be applied for high contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, assisting with toileting, device care, and wound care. Observation on 3/18/25 at 11:55 AM identified 2 physical therapy staff members walking into Resident #404's room without the benefit of applying PPE per the EBP sign. Interview and observation with LPN #2 on 3/18/25 at 11:57 AM identified that Resident #404 had been diagnosed with an active MRSA in the sputum. Observation of the EBP precaution sign with LPN #2 identified the precaution sign posted was not accurate given the active MRSA diagnosis. She stated the sign should have indicated droplet precautions, (to apply a mask, gown and gloves) and that the 2 physical therapy staff members would not have known to wear the correct personal protective equipment due to the incorrect signage. Additionally, the physical therapy staff members were on their way out the door with Resident #404 when LPN #2 stopped them. She informed the physical therapists of Resident #404 diagnosis indicating the Resident #404 required a mask on exiting his/her room. Subsequent to surveyor inquiry LPN #2 explained the active MRSA infection to the physical therapists, that Resident #404 should not have been on EBP, and he/she should have been on droplet precautions. The physical therapists had Resident #404 remain in his/her room. LPN #2 verbalized that she would be changing the signage to reflect the appropriate droplet precautions for Resident #404. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident # 407's diagnoses included Vancomycin Resistant Enterococci (VRE), an MDRO in the urine, gastroenteritis, and alcoholic hepatitis. a. Observation of NA #3 on 3/19/25 at 11:25 AM identified him outside of Resident #407's room with a contact precautions sign posted, he applied the gown then one glove without the benefit of hand hygiene prior to applying the PPE. Interview with NA #3 on 3/19/25 at 11:30 AM identified it was facility policy to foam in and out, stating that although it was not facility policy, he always performs hand hygiene before applying gloves and after taking them off. NA #3 identified he did not perform hand hygiene prior to applying the gown and glove, but he should have, he then removed his gloves and performed hand hygiene by using the alcohol-based hand rub that was located on the wall. b. Observation of NA #2 on 3/17/25 at 10:11 AM identified her walking down the hallway while wearing gloves, she took off one glove at the nurses' station, picked up a drink and took a sip, then reapplied the same glove without the benefit of hand hygiene. Interview with NA #2 on 3/17/25 at 10:16 AM identified the facility policy was no gloves in the hallway, but hers were clean. She failed to identify the facility policy on hand hygiene, with glove removal and reapplication, stating she was new and just orienting and could not recall if she received education on infection control. Review of the new hire orientation packet identified that infection control; hand hygiene training was provided. Review of the MDRO policy dated 4/16 directed that when a resident tests positive for a MDRO, they will be placed on appropriate precautions as soon as the facility is notified of a positive result. Review of the Hand Hygiene policy dated 4/2017 directed, in part, the facility considers hand hygiene the primary means to prevent the spread of infections and directed use of alcohol based hand rub before and after direct care with residents, before handling clean or soiled dressings, after removing gloves, before and after isolation precaution settings and as a final step after removing and disposing of PPE. Review of the Non-sterile Dressing policy dated 6/2023 directed in part to wash hands or hand sanitize prior to the procedure and between glove changes. Review of the Enhanced Barrier Protection policy dated 8/2023 directed in part the use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, in residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for a resident with a MDRO infection or colonization. Review of the Contact Precautions policy dated 8/2023 directed contact precautions were required for care of specified residents with documented or suspected infections for highly transmittable or epidemiologically significant pathogens. 51102

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on interviews, record review, and policy review, the facility failed to provide all staff with abuse and neglect training and failed to develop staff training for abuse that included federal components for abuse education. The findings included: 1. A review of abuse and neglect training documentation identified education was provided for new hires during orientation and during in-services that had occurred in May 2024, September 2024 and March 2025. Review of the sign-in sheets identified 31 employees had not received any abuse and neglect training (19% of the facility employees). Interview with the Administrator on 3/27/25 at 2:03 PM identified that the facility policy training program for abuse and neglect training directed all staff were in-serviced annually. Additionally, the Staff Development nurse was responsible for ensuring all employees received the mandatory in-service training on neglect and abuse. Interview and in-service signature record review with the Staff Development Nurse on 3/27/25 at 3:25 PM identified that it was her as well as the Director of Nurses responsibility to provide staff with abuse and neglect education annually according to the facility training program policy. Review of the abuse and neglect training sign-in sheets with the Staff Development nurse identified that 31 staff members, employed prior to 2024, had not received the directed mandatory abuse and neglect training. The Staff Development nurse was unable to explain why the facility failed to implement their policy ensuring all staff received abuse and neglect training on an annual basis. Interview with the HR Director on 3/27/25 at 4:07 PM identified there were 164 staff members currently employed at the facility, and the 31 employees identified as not having had abuse and neglect training since prior to 2024 were still currently employed with the facility. The Director of Nurses was not available for an interview. The facility assessment dated [DATE] identified staff is educated on abuse, neglect and exploitation. The Preventing Resident Abuse training policy dated 4/2016 directed, in part, the facility abuse prevention/intervention program included regularly scheduled in-service programs. 2. A review of the Abuse Training for staff identified that in-services occurred on 9/13/2024, 9/16/2024, 9/19/2024, 9/20/2024, 9/27/2024, and 10/18/2024. The seven components of the requirement include: Screening Training Prevention (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Identification Investigation Protection Reporting/response Although the training did discuss investigation, protection, and a portion of reporting/response (page 1), it failed to address the screening of residents (current and new admissions) for abuse, identification of physical or psychosocial indicators of abuse (including injuries from an unknown source), mandated reporting, and/or reporting allegations without fear of reprisal. Additionally, the training lacked misappropriation of resident property, resident exploitation, chemical and physical restraints, recognizing signs of burnout, frustration, and stress that may increase the risk for abuse, and dementia management for resident abuse prevention. Interview with the Staff Development nurse on 3/25/2025 at 10:48 AM identified she did not create the abuse training she provided to staff, and it was given to her when she started her role as Staff Development nurse. She further indicated the DNS was responsible for the accuracy of the abuse education and ensuring it matched the facility policy. The Staff Development nurse stated she had never seen the facility policy on abuse and believed the training did not match the policy on abuse because someone didn't take the time to read the policy when creating the education. A follow-up interview with the Staff Development nurse on 3/25/2025 at 12:02 PM identified that she was aware the staff abuse education was not sufficient, and she failed to review and update the information. Further, she indicated she was directed to include the abuse policy to staff during abuse training beginning in November 2024 and failed to start distributing the abuse policy until March of 2025. An interview with the DNS on 3/25/2025 at 11:03 AM identified that abuse education was created by the Staff Development nurse, and it had been reviewed by him prior to staff distribution. He further identified that the abuse education should be based off the facility policy. Review of the facility's Preventing Resident Abuse policy identified, in part, that the facility will not condone any form of resident abuse and will continually monitor the facility's policies, procedures, training programs, systems, etc. to assist in preventing resident abuse. 51182

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 51182 Based on interviews, facility documentation review, and facility policy, during the extended survey, the facility failed to provide staff with mandatory training on the QAPI program or how to communicate concerns, problems or opportunities for improvement. The findings included: Interview with the Administrator, Regional Registered Nurse (RN) #4, and Regional Registered Nurse (RN) #8 on 3/27/25 at 9:46 AM identified the facility had a Code of Conduct policy, but this Code of Conduct was not communicated to the entire facility staff. The DNS was unavailable for interview. Although requested, a policy was not provided. The Code of Conduct policy failed to include the basic components of utilizing a QAPI program.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 51182 Based on interviews, facility documentation review, and facility policy, the facility failed to develop a compliance and ethics program and failed to provide staff with compliance and ethics training. The findings included: Interview with the Administrator, Regional Registered Nurse (RN) #4, and Regional Registered Nurse (RN) #8 on 3/27/25 at 9:46 AM identified the facility did not have a compliance and ethics program and also did not have a compliance and ethics policy. It was further identified that compliance and ethics training is not part of new hire orientation or annual training. RN #4 and RN #8 stated there was a Code of Conduct policy, but this Code of Conduct is not communicated to the entire facility staff. The DNS was unavailable for interview. Although requested, a policy on Compliance and Ethics was not provided. The Code of Conduct policy failed to include the basic components of an ethics and compliance program including but not limited to: identification of a compliance officer or committee; how and who to report ethical concerns to; secure, confidential, and timely reporting of concerns; conducting internal monitoring and auditing for compliance and ethical concerns; response and corrective action to detected offenses; and risk assessment.

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F 0949 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on interviews, record reviews, and the facility assessment, the facility failed to provide facility staff with behavioral health education as identified on the annual assessment. The findings included: A review of the facility assessment dated [DATE] identified the facility was able to admit residents that needed care for psychiatric/mood disorders such as psychosis, impaired cognition, mental disorder, depression, bipolar disorder, schizophrenia, post-traumatic stress disorder, anxiety disorder and behaviors that need interventions. Additionally, the assessment identified Nursing Assistants (NA's) were provided with education on combative care and those with behavioral disturbances. Review of the in-service calendars dated March 2024 through March 2025 failed to identify scheduled behavioral health training by the facility or by the psychiatry services group. Review of the behavioral health education dated 3/26/25 identified a Personality Disorders in-service provided by the psychiatry services provider with a sign-in sheet consisting of 19 staff members (the facility employs 164 employees, a compliance rate of 11.5%). The facility failed to provide any other in-services with sign-in sheets on the topic of behavioral health. Interview with the Administrator on 3/27/25 at 2:03 PM identified, on average, 50 residents residing in the facility had behavioral health needs (average census ranging between 102 and 108). He identified that staff should be receiving behavioral health education, and the education was provided by the psychiatry services provider on a regular basis. Interview with the Staff Development nurse on 3/27/25 at 3:11 PM identified behavioral health education was provided on a regular basis by the psychiatry services group, and her role is to schedule the education and put the information on the in-service calendar. She could not provide any past in-service sign in sheets where behavioral health education occurred. Although requested, a policy for behavioral health was not provided.